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Unto You is Born

And there were in the same country shepherds abiding in the field, keeping watch over their flock by night.

And, lo, the angel of the Lord came upon them, and the glory of the Lord shone round about them: and they were sore afraid.

And the angel said unto them, Fear not: for, behold, I bring you good tidings of great joy, which shall be to all people.

For unto you is born this day in the city of David a Saviour, which is Christ the Lord.

And this shall be a sign unto you; Ye shall find the babe wrapped in swaddling clothes, lying in a manger.

And suddenly there was with the angel a multitude of the heavenly host praising God, and saying, Glory to God in the highest, and on earth peace, good will toward men.

LUKE 2: *Verses 8-14*

IT SEEMS particularly appropriate that an issue of our *Journal* that is devoted almost exclusively to the care of the expectant mother and her infant should be associated with the Christmas season, when we celebrate the birth of the Christ-child.

Modern obstetrical practices in Canada are very different from those primitive surroundings of nearly two thousand years ago. Then, there was no such thing as prenatal care by qualified physicians and nurses. There were no maternity hospitals, emblems of shining efficiency. There was not even a bed available in an inn for the young woman who was shortly to give birth to her first Infant. Probably she was as terrified as any young mother would be today at the prospect of having her Babe away from the shelter of her own humble home, surrounded by crowds of strangers. Pushed about, weary, in pain, the stable must have seemed a veritable haven on that night so long ago.

Even the excitement created by the radio transmission of news of important events in the world today is eclipsed by the magnificence of the chorus of the "heavenly host" that heralded the newborn Babe. "Good tidings of great joy, which shall be to all people," the angel said. We, in the middle of the twentieth cen-

tury, tend to be a bit blasé about so many things. Yet the angel's message was addressed, not just to a particular group of persons, not to any one race or creed but to "all people." Thus if we today accept the story of Christ's birth, in any degree, we should accept the whole inference of what His coming meant on earth. For the angels prophesied "on earth peace, good will toward men."

As the coming of a new infant brings happiness to the hearts of his parents, so may this anniversary of the Babe born 1950 years ago bring to all of us peace and good will. We need them both so badly in our everyday affairs, in our personal lives. Science has brought us improved practices in obstetrical care, new techniques for the safeguarding of the health and well-being of mothers and babies, better knowledge and understanding of the importance of mental health for the whole family, but it has not given us any prescription for finding "on earth peace, good will toward men." The good tidings of the angels are still the surest way to find both. May the spirit of Christmas live on in each of us!

Some Vital Statistics

The preliminary report for 1948 of the Vital Statistics Section, Health and Welfare Division, Dominion Bureau of Statistics, has recently been issued.

Masses of tabulated figures sometimes appear boring but when it is realized that these represent the annual end results of the active programs for the health conservation of millions of Canadians, the figures take on new meaning. For instance, 347,307 new citizens were registered as live births—a rate of 27.0 per 1,000 of the population. This was a drop of 1.6 per 1,000 from the previous year but is still higher than the average rate over the past 25 years. There were two sets of quadruplets, 36 sets of triplets, and 3,940 pairs of twins born during the year.

Stillbirths showed a continuing decline—19.7 per 1,000 live births as compared with 31.5 per 1,000, 25 years ago. A total of 6,849 pregnancies that terminated in stillbirths meant a great many heart-aches to parents.

The neonatal mortality figure (deaths of infants under 1 month), 8,897, produced the same rate as the year before—26 per 1,000 live births. These deaths accounted for more than half of the total deaths of infants under one year of age—15,164.

British Columbia had the lowest infant mortality rate of any of the provinces and in its provincial history—33 per 1,000 live births. New Brunswick was highest with 61. Quebec had a new low of 54.

Prematurity still led as the greatest cause of infant deaths, with congenital malformations second. Diarrhea and enteritis continued to take far too heavy a toll, accounting for 1,472 deaths. Birth injuries and bronchopneumonia each caused 1,451 deaths. These five causes were responsible for 10,259 of the deaths of infants under one year—just over two-thirds of them. These figures clearly indicate where more stress needs to be placed in the infant welfare programs in our country. What can be done to reduce the number of premature deliveries? Can the number of birth injuries be lowered by increased care at the time of the delivery?

A total of 510 women died from maternal causes, producing a rate of 1.5 per 1,000 live births. With all of our new knowledge of blood chemistry and with the remarkable range of antibiotics that are available, this rate should continue to fall. Increased prenatal supervision to discover potential difficulties is a real challenge.

The biblical life span of "three score years and ten" has long since been outstripped. During 1948, 48,178 of the deaths that occurred or 40.3 per cent were of persons over 70. In fact, there were 672 who had lived to be over 95 before they passed away.

The ten leading causes of death for all ages and their rate per 100,000 population during 1948 were: diseases of the heart, 263.6; cancer, all forms, 126.4; cerebral hemorrhage, 79.1; violence, including car, train, and air accidents, 69.7; nephritis, 52.9; pneumonia, 44.3; pulmonary tuberculosis, 31.2; diabetes, 20.3; diseases of the arteries, 18.3; diarrhea and enteritis, 14.0.

Changing Maternity Service in a Changing World

HAZEL CORBIN

Average reading time — 26 min. 12 sec.

TOO MANY PEOPLE have looked into the blank faces of children in displaced persons' camps ever to be satisfied again with the *status quo*. The product of broken homes, deprived of their birthright of love, even in some cases of their identity, these children are the epitome of a lack of security which is the chief disturber of the peace—international, national, and personal—in this day.

The young men who have been to war, deprived of their normal family life, the young women who have pulled up their roots and trundled from town to town and city to city after their soldier husbands until they said "goodbye" at some port of embarkation, know what lack of security means. These young people now place a high value upon the homes they are setting up and the physical and emotional security they are trying to build for themselves. They are resolved to achieve and maintain this security. Those who have an interest in a better tomorrow see in this family security one of the keys to national and international strength and security. It is the people who have built for themselves a firm foundation who may yet wield the balance of power in a world torn by opposing forces of almost equal power. Wherever you look today, you see inconclusiveness of political or social action because the pros and cons are almost equally matched. Mr. Attlee finds it difficult to carry on a government policy when his opposition is almost as strong as his support. Belgium is almost equally torn between those who are pro- or anti-Leopold. In our own land (U.S.A.), the last popular vote for President indicated that Republicans and Democrats are nearly equal in number. Most constructive and progressive legislation is stymied in Congress because opposing forces are nearly equal. This neat balance at which the world has arrived causes instability and lack of forthright action in any direction. This neat balance, however, can be shaken by only a few. A few shots fired by hotheads could cause a world cataclysm; a few words of wisdom by people who are secure in the midst of insecurity could help to break the deadlock. We who are working at the very roots of family security have upon our shoulders a momentous responsibility in these times.

The value which our young people are placing upon security in the family is evidenced by the rise in the birth-rate contrary to the prophecies of the statisticians. The year 1949—the year when all the experts believed the big postwar drop in the number of births would occur—produced the second largest baby crop in the history of the United States.

Worldwide forces have intruded even into the techniques and methods of obstetric and pediatric care. The trends which we see today in these two fields are without doubt the result of a search for security in an unstable world; for it is the young married people who have been through the disorientating experience of war—eager for security, resistant to unreasonable regimentation—who are the consumers of maternity and pediatric care. They are looking for security when they have their babies and they highly prize being together to share the great experience. Childbirth is, as one young mother wrote, ". . . the most intense experience I expect I will ever have this side of death. It certainly is the supreme

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time in one's existence." Young people want to make the most of this supreme time. They do not want to be cheated emotionally or physically and they have a right to make this demand.

The Patient as a Consumer

Notice, I use the word *consumers* of maternity and pediatric care. That expresses a changed concept which is having and will continue to have an increasingly profound effect upon the provision of care. Not many years ago a large proportion of the people who had their babies in hospitals went there because they had no other choice. They entered the charity door and they lay upon charity beds. The charity, however, which was dispensed was only faintly redolent of that described by St. Paul as "the greatest of these." The patients took what was provided whether they liked it or not because there was nothing they could do about it. I remember entering a maternity clinic before the war where the air was fetid with the odor of bodies like the New York subway at rush hour. On the hard benches sat a grim lot of women waiting for their numbers to be called. Others stood around unable to find seats. I asked the famous professor who headed this obstetric service, "Why not provide at least enough benches for these mothers to sit on?" He replied offhandedly, "Oh, they don't mind standing—they're used to it!"

Today everybody pays in a hospital. The ward beds cost as much in many institutions as private rooms five years ago. In addition, an increasing number of the people who used to be charity patients or teaching material have paid their own hard-earned money for insurance policies of the Blue Cross or Blue Shield or other company or union-organized medical or hospital plans which state that they are entitled to care without the stigma of grudging charity. They do not want to be a number or to be patronizingly called by their first names. They don't want to be told to sit there or come here. They don't want to be examined needlessly by numerous medical students while the private patients are treated with respect. They do not want to have their visitors limited or barred because of "the danger of infection" while they see a stream of visitors to the private pavilion where, for some reason, the danger of infection does not limit visitors. They want simple, warm-hearted acceptance. They want the same thing you would want for yourselves or the doctor for himself if you or the doctor were the patient. In addition, they pay for their insurance and they expect their money's worth. Therefore they reserve the right to speak out when they don't like the care they receive. They reserve the right to select their doctor or hospital as they would the other services or commodities bought in the open market—whether it be an armchair or fresh fish.

The Consumer is Rebelling

Is it not understandable then that a clash should arise between these consumers with their newly found economic power, their searching demand for security, their distaste for unreasoning discipline, and the suppliers of that care—the doctors, nurses, hospital administrators? The root of that clash is found in an attitude of mind among the people who provide the care—from the hospital board member to the receptionist in the clinic. Many of these people don't recognize that a revolution has already taken place in the minds of the consumers. They still speak of the "indigent" or the "medically indigent" as if they were different kinds of people from those who were able to pay their way in full. They still divide the sheep from the goats, with one kind of treatment provided for the sheep or the private patients and another for the goats or the ward and clinic patients. Medical charity has put its chief emphasis upon making it as simple as possible for the doctor and the nurse to care for the largest number of patients at the cheapest cost without full regard for the effect of this upon the personality of the patient. It has applied

the mechanized economics of the mass production assembly line to human beings. This kind of care ignores the findings of psychosomatic medicine and the relation of the emotions to physical health, and of all this to sound, happy family living.

In addition, medical care is dispensed under a discipline which is autocratic, against which today's young parents are in revolt. The doctor says, "Take this prescription." It is an order. If he is asked why, he may simply say, "Because it is good for you." He may oppose having expectant parents taught anything at all about reproduction because it causes them to ask questions which take time to answer, and he is busy. He may talk about a mother in long medical terms to a colleague while she lies before him on an examination table all aquiver, understanding nothing he says. The doctor may tell Mrs. Jones not to bother her little head about her labor. "When you come to the hospital, we will give you a whiff of something to knock you out, and we will take care of everything," he says in a dignified and rather superior manner. This may be entirely regardless of the mother's own desire to take part in the birth of her baby and to be present when he is born.

These young people who put such a premium upon being together, upon family security, are separated from the moment the husband brings his wife to the hospital door to have their baby. He is firmly but gently ejected from his wife's room or bedside and too often even from the hospital. The baby is separated from its mother as soon as it is born and from its parents during the stay in the hospital. Often the mother is not even consulted about whether she will nurse her baby or not. She is simply given a standard dosage of stilbestrol to dry up her milk supply. She lies in bed with empty arms while her baby may be seeking cold comfort from an empty bottle propped on a diaper.

The clock has become the symbol of this regimentation. The system of hospital care with scheduled hours for nurses, shifts of duty, meals and visiting hours, admissions and discharges requires scheduled times for feeding the baby regardless of the rhythm of the baby's own demand for food.

Teaching Problems

As for teaching, that is shrugged off in many hospitals with a perfunctory session of instruction on diapering or bathing the baby. Often nothing is taught the parents about how their baby is conceived, how he grows and is born, of the adaptations the mother's body makes to supply her needs and the baby's, and the effect of all this upon her emotionally; nothing about the reasons for various techniques of medical care; nothing about nutrition and its importance to the healthful growth of the baby and the health of the mother; nothing about what to expect during labor; nothing about what a newborn baby is like and what he needs; nothing about family relationships at baby-coming time. Many of these hospitals affiliated with universities are called teaching institutions, but whom do they teach? Certainly not the parents. The emphasis is on teaching the medical and nursing students. And yet what is the function of medical care in this land where public health is so much talked of?

A grievous sin is committed against humanity when obstetric teaching takes priority over obstetric care. In no other specialty of medical care is the medical student permitted to assume responsibility for the life of the patient—in this instance two patients: the mother and her baby. Few medical students are permitted to do even minor surgery but every medical student has a number of opportunities to deliver women, often supervised only by an interne, himself still a student with much to learn. It is in this atmosphere of the blind leading the blind that the nurse is taught. At the centre of this teaching experience is the forgotten woman—the mother.

It is upon her and her baby that all interest should be focused. When

maternity care of the best quality is provided the teaching opportunities are manifold but, in order to teach, a qualified teacher must be present to teach the students. And if nurses and doctors are to learn how women have babies and how they can be helped throughout labor, then one or the other must sit with the woman.

A growing number of doctors are disturbed by this lack of good teaching of medical and nursing students in situations where the mother is not the focus of interest—they see its influence on both the students and the mothers. They have observed the damage done to a woman who is treated as a uterus, to the family treated as pegs in a board to be moved at will.

Obstetric Practices

More than that, many doctors are keenly conscious of the number of needless deaths among newborn babies due to anoxia caused by anesthesia—babies with apparently perfect bodies whose heart-beats ceased before they could be made to breathe. These doctors warn that many neonatal deaths are due to brain damage in the respiratory centre caused by lack of oxygen. Dr. Alfred C. Beck, professor emeritus of obstetrics at the Long Island Medical College, puts it this way:

> When the mother's respirations are slowed and made more shallow by the use of sedative drugs and anesthetics, the oxygen supply to the placental lake is diminished, and the danger of intrauterine anoxia and asphyxia are increased to such an extent that most of the methods which have been recommended for the relief of pain during labor may cause the death of the child if they are not given with caution.

Beck is not alone. Many others from various fields are saying the same thing—Snyder of Harvard, Stone of Yale, Darke of Pennsylvania, and others.

In addition, the epidemics of infantile diarrhea which suddenly sweep into a hospital nursery, terrorizing not only the parents but the professional personnel as well, cause many a doctor to question the present system of caring for babies in large nurseries. Others who have witnessed the unsatisfactory after-effects of routine episiotomies among hundreds of mothers are beginning to question the practice of substituting a routine surgical operation for what might be a routine spontaneous delivery.

To add to the dissatisfaction within the pale of maternal care, many nurses are not attracted to obstetrics. They have no desire to participate in care which separates mothers from their babies and their families by rules and gloves and masks and routines. They see the importance of love and affection and security at this important time in the life of each family and yet they are unable to afford the mothers under their care the opportunity to cuddle or love their babies or to develop a feeling of security. Some see the coming of a baby as an ideal time to teach the facts about reproduction and healthful, happy family living which are omitted from almost everybody's education. But there is no time, no place in the day's work for such teaching.

Often we hear such comments from nurses as, "We are not allowed to stay with women in labor. It interferes with the medical student." Or "Where we do attend women in labor, we must go off duty at a specified hour, even though the mother begs us to stay with her, and we want more than anything else to remain until the baby comes."

Thus the system stands between the patient and her professional helper. The nurse who has ideas and ideals resents the system and is unhappy under it. She hears about the medical team of doctor, nurse, technician, and patient but, as she goes about her daily job, she feels the team is not in harness. Little opportunity for professional creativeness is provided in this branch of medicine concerned with nature's supreme creation.

Leaders in medical care are greatly perturbed as they see the nutritionist intent on food values, not people, the laboratory workers on bacteria, the housekeeper on her laundry, the

medical board intent on medical matters and research, and the administrator on economy and efficiency. The board of directors of the hospital in whose hands the community vests the power frequently doesn't know what goes on within the hospital in terms of people but considers the job well done if the halls are clean, the windows washed, and the building filled with bustling activity.

New Demands

The laws of supply and demand are beginning to operate in medical care as they do in the sale of automobiles or refrigerators. We can no longer sit on an Olympian peak and determine what shall be done to people without considering what people want. In the last analysis they must pay for it, directly out of pocket or indirectly through taxation. When people want something, it is produced. We see a demand developing from the public and the professions alike, a demand for a different kind of obstetric care centred on the needs and desires of the mother and her baby as part of a family group.

In response to these desires and demands, little by little and step by step the shape of things to come is beginning to take form in the research centres of a number of great universities, in the wards and private rooms, in the clinics and nurseries of certain important hospitals, in the private offices of sensitive obstetricians and pediatricians, in their daily rounds among their patients, and in their work in the maternal and child health centres; and in the everyday relations of nurses with parents and doctors.

In response to young parents' demand for more knowledge and their resistance to the autocratic "do what you're told" system, classes on a high level of instruction are being organized for both mother and father and conducted under various auspices. Parents with a keen desire to know about childbearing scorn the traditional mothers' or fathers' classes with their chief emphasis on baby care and pink and blue ribbons. These eager young people want to glean every last scrap of information they can—for a purpose: they want to know how to live during pregnancy and how to prepare for labor so they can participate actively in the job. And the mother wants to do it with her eyes open and to see what goes on. She wants to be the first to announce, "It's a boy."

Armed with such information, young parents are able to understand the reasons for medical or nursing techniques. They know why the doctor does this or that at certain stages of pregnancy or labor. But more, they learn how knowledge can build within them a feeling of supreme confidence in their ability to have their babies according to nature's plan in which they do the work and reap the reward.

Caring for mothers as well educated as this is a challenge to the doctor and nurse. Their functions in obstetrics are changed. No longer do they hold a mystical power, no longer do they do something *to* the patient. Rather they become the coach and sympathetic guide as well as teacher and competent practitioner during labor. For many doctors and nurses this adjustment is difficult in the extreme. For others, still only a few, it has become a challenge to their knowledge and ability to work *with* people rather than *for* them. This is a testing time for the quality of the contact established between doctor, nurse, and mother, and all get tremendous gratification out of this intimate teamwork. As both parents take a more active role, doctors and nurses modify their techniques and methods. For instance, as the exercises for relaxation become important in obstetrics, the doctor and nurse learn how to provide the necessary support during labor within the facilities provided by the hospital.

Even the technique of relaxation has altered some of the early signs of labor, for a relaxed woman is often far along in labor before she, her husband, the doctor, or the nurse recognizes it. Many a primipara has brought forth her baby in from one to three hours after admission to the hospital because her early labor was

not uncomfortable enough to her or significant enough to her doctor to warrant an earlier trip to the hospital. This means that we must revise our teaching about the early signs of labor; it also means we must make some first-hand observation of what happens during late pregnancy and early labor, and we will be wise if we listen well to what the patient and her husband have to say about it.

Sharing the Birth Experience

Perhaps one of the most important of these changes is the recognition that the laboring mother needs human companionship. One of the greatest mistakes ever made in obstetrics is the custom of leaving the woman in labor alone and uninformed. It is then that fear grips her heart and anxiety beclouds her mind. It is then that pain overwhelms her and the demand for complete anesthesia becomes insistent.

The hospitals which have permitted the husband to stay with his wife during labor, and in some cases to be with her in the delivery room, are finding that these procedures, unorthodox as they may seem, increase the emotional security of both husband and wife during this important event in their lives. When a woman wants and has her husband with her during this important time to coach her and to love her and to help her relax, the demand for complete oblivion diminishes. Less anesthesia means fewer babies dead or injured from anoxia. It means more mothers conscious and keenly aware of what happens in the delivery room. But it also means a revolution in the technique of delivery and in the administration of the obstetric department. Doctors, nurses, and administrators are learning to adjust to the husband's active part in helping his wife to relax in the labor room and the delivery room. Often this causes extreme difficulty because hospitals were not built or organized to accommodate the husbands during their wives' labor and delivery.

The security which develops among the parents and the revolution required in obstetric management are graphically portrayed in this scrap from a mother's description of her first baby's birth:

> It took only a few good shoves till I felt my baby's head pop out and her body coming out. It felt like a swimming goldfish. Bob was standing at the peep hole so we yelled back and forth through the glass and grinned at each other.

Yes, if these demands of parents are to be met, it is going to take a bit of imagination, more knowledge, an improved relationship between doctors and nurses, and a wagon-load of courage. Yet the doctors who have those qualities today are finding that for them normal obstetrics becomes more interesting and more satisfying. As one physician wrote:

> It's more emotionally satisfying to the doctor to care for a conscious mother who talks with him as he directs her efforts in labor than to sit with one who is trying to crawl up the wall, muttering incoherently from analgesia.

Obstetric nursing, too, becomes a thrilling and interesting experience as the nurse learns to help the mother relax and work so she can have her baby naturally. It is a challenge to her teaching ability and to her knowledge of anatomy, physiology, obstetrics, and people.

The hospitals which have worked out methods of keeping mother and baby together, call it rooming-in or what-have-you, have watched the blossoming of security in the faces of both parents. Not only is the family unit knit closely at the very earliest possible moment, but the mother and father who learn to care for the baby under supervision in the hospital develop a feeling of confidence. The young parents who take the baby home after such an experience are ready and able to assume their full responsibility. They are not taking home a baby wrapped in cotton and cellophane they are afraid to touch.

The Crossroads

Are we ready to apply this new relationship between professional staff and parents, and the new techniques of maternity care which are springing

up in response to popular demand and professional dissatisfaction, to obstetrics in big city clinics and country doctors' offices, in hospital delivery room, and farm-house bedroom? "Stop, look, and listen!" . . . "Proceed with caution." . . . "We need more research before we dare make universal such changes in obstetric care," warn some of the less imaginative and adventurous.

True it is that medical progress is dependent upon research. The more we know, the better can be the care provided. But is it lack of research, lack of knowledge that stands in the way of obstetric progress? Or are we in the doldrums? Are we the victims of tradition—tied, like Marley, to a rusty system? Are we tarred with the same brush as a recent contributor to *The Lancet?* said a British doctor:

> A public avid fof medical knowledge is a public to be pitied . . . The profession was able to do much more good when the public had unquestioned confidence . . . The less they know, the happier they are.

Have we oversold ourselves on institutional, mechanized care? In order to make more efficient the care provided in hospitals, have we lost the essence, the heart and soul of that care? I think we have! With proper safeguards properly centred in our community a home service offers something very wonderful that is all too often lost entirely in a hospital. The problem is not so much one of lack of knowledge as of attitude. Are we going to stand idly by and let anesthesia take the place of education; chemotherapy supplant known methods of preventing infection; blood transfusions replace a loss of blood which might have been prevented? Are we going to accept routine episiotomies and delivery by forceps rather than assistance to the mother in delivering naturally by using the muscles designed for this purpose?

We nurses stand at an important crossroads. Shall we continue to be merely the hands and feet of others when often we disagree? Or shall we take our place with the leaders of the medical profession and the community at large?

Rule or Reason

The direction which nursing takes in the future is at this very moment being decided in countless little episodes such as this:

> Recently a well trained nurse who had specialized in obstetrics for years attended her sister in a university hospital. Her sister had had her first baby normally with a very short labor. In this second labor, things progressed as expected. When fully dilated, the mother was taken to the delivery room—but her doctor had not yet arrived. Two or three more contractions and the baby would be born. However, against the patient's protest, her legs were held together to hold the head back and she was ordered anesthetized.
>
> The well trained obstetric nurse urged that the baby be allowed to deliver rather than held back but the supervising nurse said, "No, we must wait until the doctor comes!" For thirty minutes, this woman was kept under deep anesthesia. Finally the doctor arrived and, after the patient was allowed to come out of the anesthetic sufficiently to recognize and speak to her doctor, she was again anesthetized. He performed a deep episiotomy and delivered the baby from the unconscious woman by forceps. Uterine inertia, a severe hemorrhage and, a day or two later, infection caused this mother to pay a terrible price in suffering, lack of vigorous health, and cash for many months.

If I were to ask a group of obstetricians: "On the basis of the facts I have given, do you feel it would have been better to deliver that baby than to strap the patient's legs together and anesthetize her for half an hour?" I am sure of their answer. They would chorus, "Yes, it would have been better to deliver her!" I am sure that if each of you should ask the obstetrician whom you work with and trust the same question, his answer would be, "Yes. If it were my wife or my baby, I would want the delivery to take place. It is good practice!"

This situation represents a clash not between the doctor and the nurse but rather a clash between two nurses—one standing for the *status quo*, the

system regardless of its effect upon the health of a mother and baby, the other standing for good care which puts the mother and her baby at the centre.

As I pondered the question, which some people would file under ethics, I turned to the *Century Dictionary* to find out just what it says about a nurse, and the definition is: "One who nurtures, trains, cherishes or protects." I found myself asking who that nurse was protecting, cherishing, nurturing, training? Now I leave you with the same question to ponder, but I will ask you another: What should she have done? Let us assume that in the first place the supervising nurse would not have been there had she not been trained to attend a normal patient and deliver her if necessary. And, since she was trained, should not her prime consideration have been the woman and the baby and shouldn't she have delivered her? I would say yes, a thousand times yes! Any rule which makes that course impossible is a rule to be broken—broken not behind a closed door but out in the open. Now had the sister of the patient insisted upon this, there would have been a clash of opinions and of authority.

Should she not have said, "I refuse to let you hold back the baby!" Only by such willingness to stand for what is right in terms of the life and health of the people we serve can nursing make its greatest contribution to medical progress. Remember, the world does not go forward with the unreasoning conformists but with the people who have the courage and imagination to do the things they believe are right—yes, even to breaking the rules!

I would remind you that a nurse named Nightingale, a nurse named Kenny, a nurse named Cavell, a nurse named Sanger, had the courage to break the rules—and make the rules—in the interest of the people they served. It is through these people and many others like them that nursing has gone forward. And so we find ourselves in a changing world—no, in a changed world—and we have many changes yet to make in our profession if we are to carry the lamp—brightly burning!

Criticism

No one really escapes criticism and the more eminent one is the more criticism may be expected. That is a price one pays for holding a distinguished position. It is as Addison said in his essay on *Censure*—"Folly to think of escaping it and weakness to be affected by it." There is no defence but obscurity.

Fair criticism implies a desire on the part of the critic to judge with clarity and say with honesty what he believes to be true. His judgment will be based upon his own experiences, his disappointments, his burned fingers, and his beliefs. At the same time, he will make an effort to get the other fellow's point of view and take the gentle and indulgent side of most questions.

Fair criticism does not judge without factual information. It considers the event on which it is to pass judgment in the light of these factors: what was said or done? what did the person mean to say or do? what was his reason for saying or doing it? what is the effect of what he said or did? why do I object to it?

If we are on the receiving end of criticism, we must school ourselves to rise above all that is petty and to accept and use what is worthwhile. There are times to fight back but these must not be decided by inclination but by answering the question, after searching consideration of the criticism: Is it right?

—*Royal Bank Monthly Letter*

Christmas

It is an old *Irish* custom to place a candle in the window on Christmas Eve to light the Christ-child on his way and the use of a candle appears in many other lands and in many different ways. In *Armenia* myriads of candles are used in the Christmas celebrations and in *Czechoslovakia* tiny candles are set upright in nutshells and floated in pans of water.

Nurses' Part in a Prenatal Program

KATE MCILRAITH

Average reading time — 10 min. 24 sec.

THE AIM OF a maternal hygiene program should be a healthy woman giving birth to a healthy full-term infant and making a satisfactory return to her normal vigor so that she may enjoy to the full her function of mother and homemaker. Carolyn Van Blarcom has stated that the nurses' part in a program for prenatal care is:

> To assist the doctors in carrying out the prescribed details of supervision, instruction, and care of expectant mothers, and to work toward the ideal of having every expectant mother in the land under medical care from the beginning of pregnancy.

There is need for a well developed team-work between the nurse and the doctor. The nurse's visit does not take the place of medical supervision but is rather an interpretation of his orders for the health and well-being of the expectant mother. It is essential also to enlist the interest of all workers in the field of health and welfare and of the general public. What we must remember is that the ideal we are striving for is not that the high peaks of obstetrical care shall be higher but that *the average care given to all patients shall be raised.* This means getting every expectant mother under care and then making that care so satisfactory and effective that it will benefit her and the baby.

Today every woman's magazine and almost every daily paper feature frequent articles on maternal care by well-known authorities. Unfortunately, only a small proportion seem to avail themselves of this method of improving their knowledge of this subject. We must realize that all pregnant women are not alike in their intellectual capacity. We know that some can be taught more about health than others who may be equally interested. The nurse must learn to suit her method of teaching to the mental capacity of the patient. In some cases she will need all the information she can acquire to satisfy the patient's intellectual curiosity. In other instances, she will need to teach one idea at a time and even that one idea may have to be repeated on many subsequent visits. For the latter patient, the nurse demonstrates each subject she brings up, perhaps by the use of actual materials, perhaps merely by sketching with pencil and paper in order to reach the patient through other means than the spoken word.

In addition to differences in mental capacity, every nurse knows the effect of variations in background of the patients—racial, economic, etc. The important thing to remember about adequate maternity care is that not enough people know what it is in all its elements and not enough are putting into practice what they do know. This is as true of nurses as it is of doctors and layman. Yet if there is one field in nursing that demands a combination of knowledge, skill, and common sense, it is the maternity field.

In addition to an all-round fund of knowledge and skill, the nurse must have the ability to impart this information to others. She needs a genuine interest in what she is teaching, in the people she is teaching, as well as an understanding of teaching methods and of human psychology. In other words, what she does with her equipment of theories, facts, and skill is more important than her mere possession of them.

There are great individual differences between patients in personality, in character, and in maturity. The study of these personality differences is essential in each family with which the nurse works. The reactions and

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attitudes of the patient are a definite part of any home situation. The real test of the nurse's knowledge of maternal care is reflected in her patient's activities and reactions and those of the whole family.

The nurse has a vital responsibility to the community. The magnitude of this obligation cannot be over estimated since widespread prenatal work cannot be carried out successfully without the whole-hearted support of nurses. To demonstrate her full support and interest in this work, the nurse must be not only familiar with what constitutes adequate prenatal care, but she must be so imbued with enthusiastic interest that it will spread not only to her patients but to the community at large.

Expectant mothers may be reported to the nurse by the patients themselves, by doctors, hospital clinics, social workers, and other health workers in the field. It is not enough for the nurse to wait for patients to seek her help—she must seek the patients.

Periodic and regular visits by the nurse to the various doctors' offices make for an excellent relationship and ensure a better understanding and cooperation in this work.

Prenatal teaching may be carried out in classes for expectant mothers or by visiting in the patient's own home. Both have their advantages, depending upon the individual patient. Classes are stimulating and provide a better opportunity for discussion, a wider scope for demonstration and the use of the many teaching aids available.

The young mother of average and above-average intelligence who is expecting her first baby is the one who finds the classes most helpful. The mother with other preschool children does not find it easy to attend classes so that home visiting is more helpful to her. The mother whose intellectual capacity is limited also is assisted better when the nurse sits down in her own familiar setting and discusses one simple idea at a time.

The nurse's duty to the patient might be said to be: (a) watching or supervising; (b) teaching; (c) sustaining or giving moral support.

The nurse has an opportunity to observe the patient carefully between the doctor's consultations with the patient and to report to him. She can sift through the symptoms and give him a detailed report. Such symptoms as headache or dizziness may be significant of some complication or merely faulty health habits, fatigue, which in itself may be alarming or merely indicative of inadequate rest. The visits by the public health nurse can be as frequent as seems necessary, depending upon the physical condition of the patient, her mental attitude, and the need for instruction.

The starting point with each patient is based on what that patient knows about maternity and her ability to absorb further knowledge. The average woman needs to know why rest, good diet, exercise, and medical supervision are important to her and her baby. She needs to realize that her baby is nine months old when he is born. Once she is established on a routine of rest and exercise and understands the need to follow the doctor's instruction, that part of the teaching can be curtailed and other matters stressed. She may require little or much help with her diet which is, of course, the one advised by her physician and based on her particular needs. The amount of help she requires in planning it will usually be determined by her economic status, her intellectual level, and the amount of adjustment that is necessary.

Plans for her own clothing and that of the coming baby are usually easily made. If the mother fully understands the changes taking place in her body and the growth of the baby she will more readily understand the need for good body mechanics and the relationship to comfortable well-fitting clothing and shoes.

The birth of a baby is not purely a physiological process. There are emotional factors which are all too frequently forgotton. The whole woman—her mind as well as her

body—is involved. No pregnancy is routine. While it is true that each woman reacts to pregnancy in her own way, many of the experiences met with are sufficiently similar to produce certain recognizable reactions in the pregnant woman. Three of these are: (a) certain emotions attendant on bodily changes; (b) fear, in various manifestations; and (c) the reactions of the family to the mother's condition.

Physiological changes carry their accompanying emotional reactions. At the onset of pregnancy there is an increased activity of metabolic functions, requiring a rebalancing of the mother's physiological activities. If balance does not result, the patient may become toxic. This, in turn, is closely associated with mental irritability and depression. Little worries seem magnified and the patient may feel like a creature in a trap. She may resent her pregnancy. This is no time for the nurse to take too seriously what the patient regards as her troubles nor should she try to be convincing regarding the beauties and joys of motherhood. She should take the role of listener, letting the patient talk it out, so to speak. Perhaps on the next visit the complainant will be more serene and emotionally receptive to thoughts of the future and planning for the baby's coming.

A common reaction to pregnancy is fear—fear of death, of labor, of marking the baby, to mention only a few. Very often these patients do not admit their feelings to the family or even the doctor—sometimes, indeed, not even to the nurse. The nurse's attitudes, her sympathy, and understanding will do much to clear up these difficulties. Fears, worries, and feelings of inadequacy are not conducive to peace of mind and emotional balance.

The reaction of the expectant father towards his wife is important. His help and understanding cooperation are vital. If there is an older child it is essential that he, too, should know of the coming baby. Telling him of this expected addition not only provides an excellent opportunity for sex teaching but it will help the older child to welcome the new baby into the family circle. Without previous preparation it is often difficult for him to learn to share the love and attention of his father and mother with a new-comer.

It is important that the expectant mother should understand *how* a baby is born. When she knows how labor begins and progresses, what is actually happening when she feels her uterus contracting, what to do, what will be done to her and why, labor becomes not a dreaded ordeal but "one of life's most interesting experiences"—a marvelous provision of nature for bringing her baby into the world safely. Without this understanding, the uncertainty, the fear of impending pain or disaster, which are traditionally implanted in the minds of most women, keep her tense and anxious and disturb the neuromuscular harmony of the mechanism of labor, prolonging the whole process, causing unnecessary pain and leaving emotional scars.

Teaching mothers about labor does *not* frighten them. On the contrary the well-informed mother anticipates her baby's birth, calm and unafraid because she knows what to expect.

Christmas

It is not known with certainty when the festival of Christmas was first celebrated. It is spoken of in the beginning of the third century in the writings of Clement of Alexandria. In the latter part of the fourth century a writer speaks of it as of great antiquity. There was considerable diversity as to the day on which Christmas was celebrated until the fourth century when the Western Church fixed on December 25 as no actual knowledge of the day of Christ's birth existed. The Eastern Church had favored January 6 but gradually adopted the same date. A heathen festival of early Rome, the Brumalia, which was held at the winter solstice when the sun is, as it were, born anew, has often been mentioned as having had a strong bearing on the selection of the date.

Prenatal Classes in Greater Toronto

CONSTANCE GRAY, B.A.

Average reading time — 9 min. 48 sec.

THESE CLASSES now appear to be well established, an accepted part of the community health program in Greater Toronto. The sponsorship of the cooperative planning for these is unique. The Welfare Council of Greater Toronto in 1944 undertook, in its Division on Health, the job of coordinating the efforts in prenatal education of the health agencies in the community. This was at the request of the agencies since they felt the need of a unifying force to guide and support this project in prenatal teaching.

The Welfare Council appointed a volunteer chairman and has provided a very substantial amount of secretarial help, as well as assistance in securing considerable newspaper publicity, an item that has been found to be essential.

A Policy Committee, composed of representatives from the health agencies, was formed to help with the shaping of policy, over-all planning, and matters of budget. This committee then appointed a Working Committee to take care of the arrangements connected with the operation of the classes.

PLAN OF ORGANIZATION

As a result of these efforts three centres were opened in the east, north, and west parts of the city. The history has been one of steady growth and expansion. At present there are 11 classes, eight of which are distributed over the city and the other three in the outer metropolitan area in Etobicoke, Leaside, and East York. The classes are held in churches, Y.W.C.A., hospitals, and libraries—wherever a suitable and accessible location can be found. The total number of young mothers in the community who have attended these classes is now approximately 4,000.

The original group of community health workers were the public health nurses (the Toronto Department of Public Health, the Victorian Order, and the St. Elizabeth Visiting Nurses) and the Visiting Homemakers. To these have been added the Etobicoke Department of Health, the East York-Leaside Health Unit, and librarians from the public libraries. There is a field of service here, too, for the Red Cross volunteer who attends every class and helps with the registration of pupils, the demonstration of the baby's layette, and the serving of refreshments. The custom of providing tea has value far beyond the merely physical business of eating for it is during this informal period that many of the vital and troublesome (to the pupil) questions are brought out. The friendly contact with the teacher and with other young women facing the same hope does much to dispel the feelings of isolation, loneliness, and fear that every mother experiences at some time during her first pregnancy. The librarian attends one class in the series and brings with her a book display on relevant topics such as prenatal hygiene, infant and child care, and books for the young child.

The budget is a matter of considerable importance for any sustained effort of this nature and deserves some thoughtful consideration. The participating organizations that began in 1944 with a small budget for three classes now operate and finance 11 classes. Each agency contributes approximately in proportion to the number of teachers it provides. Three items are of interest: $70 covers the cost of the layette which includes a

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Birth Atlas (New York Maternity Centre Association); $10 provides the refreshments for a series of 10 lessons; $1.00 per class ensures adequate caretaking services.

Content of Teaching

On the basis of several previous experimental efforts with a longer series, the Welfare Council began its classes with 10 lessons. This plan has remained unchanged to the present although the content of the teaching has been altered, revised, and reorganized from time to time. The Working Committee has provided a guide of teaching material for the teachers to help them and to ensure a reasonable uniformity for the classes. This material, which has been approved by the Departments of Obstetrics, Pediatrics, and Psychology at the University of Toronto, has recently been published in booklet form and may be purchased from the Welfare Council. [See *Between Ourselves*, p. 940 this issue.]

The public health nurses teach seven of the 10 classes, the nutritionist from the Visiting Homemakers teaches two. Both teachers share in the initial class. This first one is a general introduction, explaining the purpose of the classes, the sponsoring group, and the participating agencies. The major emphasis is placed on "Foods for Health" since diet is such an important factor influencing the expectant mother's health. This is thought also to be the best class for the librarian from the local branch to attend as the pupils are interested in having the information about the library facilities in order to prepare for the rest of the lessons of the series. It has been found a practical plan to have the librarian speak at the close of the teaching hour, as the discussion of books can be conveniently carried on into the informal refreshment period.

The second class deals with the anatomy and physiology of pregnancy and is called "How the Baby Grows." This is a class that presents much new material to the mother and the *Birth Atlas* has been found to be a very helpful teaching aid.

Classes three and six are taught by the nutritionist. She discusses the normal diet and the changes required in it during pregnancy, the nutrient value of foods, and the influence of diet on lactation. This is called "Foods for You and the Baby."

The fourth, fifth, and seventh classes include the teaching of the hygiene of pregnancy. Here the mother gains an understanding of the relationship of physical and emotional reactions during pregnancy as well as the value of good hygiene. One of these classes is devoted to breast feeding, for it is hoped that these young women will all enjoy this privilege of motherhood through better preparation and better understanding of its psychological values. In these classes there is an opportunity to discuss the "old wives' tales" that every expectant mother hears, and the worries and fears that each one has.

Class eight deals with the baby's layette, a subject where discussion is always lively, and class nine draws the largest attendance of all the classes. This is the baby's bath.

The last class is called "Off to a Good Start." Its content is designed to help the new mother assume her responsibilities with confidence by preparing her for the problems she is likely to meet on her return home from hospital.

Two months after the expected date of confinement, a questionnaire is sent to all pupils who have attended more than one class. Approximately 43 per cent of these questionnaires are returned. It is interesting to note that the usual return on a general questionnaire is only 15 per cent. Our results would seem to indicate a keen interest on the part of the pupils. Needless to say, the mothers enjoy the opportunity of helping with suggestions for changes or improvements in the teaching content. These questionnaires have been an excellent means of evaluating the needs of the pupils and the efficacy of the teaching. In accordance with these findings, the content of the

teaching material has been changed and enlarged and the methods altered.

General Observations

There are some general obversations that can be made about these classes that are of interest and significance. They raise new questions and problems in this vital field of education.

The appeal of the prenatal classes has been to a group of young women who are intelligent, informed, of average economy, and who are receiving their medical care from private physicians and obstetricians. These impressions, obtained at any class, may be verified from information on the registration cards. This picture has been consistent over a period of six years. Classes tried in the poorer areas of Toronto have had to close for lack of pupils in spite of the fact that clinic patients have been referred to them in various ways. If these mothers do attend one class they usually fail to return. This problem of reaching the clinic patient is one which might be studied with profit. From every point of view they have a need for this teaching although they do not respond to the invitation of these classes. One may be reasonably confident that these mothers have as strong an interest in their babies as those who do attend. Would some adaptation of these classes or some other method of prenatal education be more effective? It seems unlikely that one set pattern of prenatal education will ever meet the needs of a city with a population as diversified as that of Greater Toronto. With these needs in mind, the committee is formulating plans for a modified series.

Another feature of these classes is the fact that the pupils are almost invariably primiparas. There were 808 of them out of a total of 871 in the season 1949-50. The remaining group of 63 pupils were made up of multipara and the occasional grandmother, anticipating responsibility for a new baby, or perhaps a mother who planned to adopt a child. The reasons for such small numbers of multipara attending these classes has occasioned some concern. This may be a matter of baby-sitting or perhaps is due to a feeling that they do not need any further instruction. If the problem should be the former, the solution is obvious and might be explored fairly easily; if the latter, it would be more difficult to assess and overcome.

Publicity has been a very important consideration. Newspaper publicity especially was felt to be essential for the attendance at the classes varied directly in proportion to the amount of it. In 1946 this type of publicity accounted for the largest number of pupils attending the classes. In 1950 we observe that friends and relatives (usually former pupils of the classes) are the best source of referrals. Physicians, who were in about fourth place when the classes began, have now become the second best source of pupils. This has been a gradual change and we may anticipate the time when the physician will be the first source of referral.

There are many other practical problems such as how to secure fresh teaching material, new ways of using the old material, the best method of preparing the nurse teachers, the value of teaching aids, the use of films, etc. The place and function of the volunteer is a matter that has been considered thoughtfully and reviewed periodically in these classes. It has been difficult to hold volunteers. Is it because their responsibilities are not sufficient and, if so, how can they be increased or their duties made more interesting?

Looking into the future we anticipate an increased need and demand for these classes. It might be noted here that the number of young women taking advantage of these classes is about 5 per cent of the total number of births—that is, the possible total of expectant mothers. This would indicate that there is still a large field for the expansion of prenatal education. The steady rate of increase in attendance would seem to substantiate this, as well as the fact that early ambulation and short hospitalization periods are now features of ob-

stetrical practice that probably are here to stay. When the new mother returns to her home her problems are manifold. Breast milk is not established. Usually the umbilical cord is not healed. Perineal care may still be required. The responsibilities for the care of the new baby loom large and serious when there is no competent hospital authority nearby to help with them. Adequate preparation and planning for these difficulties during the prenatal period will do much to eliminate them. This is in accordance with the newer thought of "anticipatory guidance," recognized as sound practice in the field of public health. That a child be "well born" is the prime requisite to a good start in life.

Nourishment for a Pregnant Woman

LUCY RANDOIN

Average reading time — 2 min. 48 sec.

IT SHOULD NEVER be overlooked that the life of a human being commences long before birth. The first nine months of its existence, passed as a "parasite" as it were in the mother's uterus, have a very considerable influence over its whole life.

Too many expectant mothers, happily preparing cradle and layette for the child, overlook the fact that, according to the manner in which they are being nourished, they will give birth either to a splendid baby or to a sickly, rickety creature, which will have to bear during its whole life the consequences of prenatal negligence.

It is, therefore, specially important that an expectant mother should carry out simple rules, more especially as from the fourth month of pregnancy.

1. *Case of a pregnant woman, in good health, presenting no trace of albumin:*

What not to do: Do not try to eat the largest possible quantity of very nourishing food, more especially starchy foods: rich bread, macaroni, dried vegetables. A pregnant woman who eats too much puts on weight and runs the risk of losing her suppleness which is indispensable if her delivery is to take place under good conditions.

Do not try to consume large quantities of fatty foods, as the milk which must be taken each day by a pregnant woman already supplies this need. An excess of fats fatigues the liver and the kidneys which are particularly fragile during pregnancy. For the same reason, avoid cooked fats.

Do not make an excessive use of such meats as liver, heart, kidney, sweetbread, etc.

Do not make a frequent or regular use of stimulants: coffee, tea, salt, pepper, and other spices.

Drink moderately during meals.

What to do: Eat every day a sufficiently large quantity of foods rich in calcium so that the baby shall not be born rickety and the mother's teeth and bones shall not become decalcified. These foods are, more especially: milk (whole or skimmed), all kinds of cheese (fresh or fermented and made from either full cream or skimmed milk), and yoghurt.

At the two principal meals take a sufficient quantity of fresh vegetables (particularly green vegetables) and, if possible, fresh fruit in order to:

(a) Combat the danger of constipation which lies in wait for pregnant women and may provoke liver and kidney trouble.

(b) Bring to the organism abundant quantities of the mineral matter and vitamins which are absolutely indispensable for the development of the fetus.

Fresh *raw* vegetables (tender green

salads, grated cabbage, grated carrot, grated turnip, celery, radishes, olives, etc.,) should be eaten every day for they have the maximum vitamin content.

If possible, in spite of high prices, take oysters from time to time.

2. *Case of a pregnant woman, presenting traces of albumin:* The advice given above should be followed but it is indispensable to avoid taking any sausage or similar products, shellfish, eggs, or heavily salted or spiced commodities whatsoever.

The consumption of meat and fresh-water fish is permitted.

3. *Case of a pregnant woman showing marked albuminuria:* In such a case a doctor must be consulted; he will indicate the regime which must be followed.

Towards Easier Childbirth

JOSEPHINE BARNES, M.D.

Average reading time — 4 min. 6 sec.

THE ENDEAVOR to relieve the suffering of women in childbirth dates back many centuries before the modern era of anesthesia. Before discussing the advances of recent years, however, it is essential to mention the new conception of the conduct of childbirth introduced by Dr. Grantly Dick Read and his followers. This centres around the idea that natural childbirth is not a painful process but that in the cultured woman the emotion of fear tends to lead to tension which of itself results in pain. The modern tendency is, therefore, to urge the mother to train herself for childbirth by the practice of relaxation, by exercising the special group of muscles that will be used, and by learning special methods of breathing which will permit her to have her baby in complete consciousness but without undue suffering. These methods are being widely practised throughout Britain and are also beginning to be used in the United States and Canada.

VARIETY OF AGENTS

For the mother who does require relief of pain in childbirth a bewildering variety of agents is now available. The most powerful pain-relieving drugs, however, are dangerous to the baby as they tend to prevent the infant from breathing normally after birth.

Childbirth can be divided into three main stages: the first—the passive stretching of the maternal passages to permit the birth of the baby; the second—the stage in which the mother, by powerful muscular efforts, expels the baby from her body; and the third—during which the placenta is delivered.

For the first stage of labor, which may last up to 24 hours in a normal first birth, the chief needs of the mother are for sleep and relief of pain. For this stage sedatives such as chloral hydrate, to ensure sleep, and pain-relieving drugs or analgesics are required. Until recently morphine and other derivatives of opium were widely used but these have now been largely superseded by synthetic analgesics which are less dangerous to the baby. Foremost among these in modern obstetric practice is the synthetic drug pethidine which was discovered in Germany in 1939. A great deal of research in Britain and America, where it is named "demerol," has established it as one of the safest and most powerful of all the analgesic agents used in childbirth. Unfortunately, the occurrence of cases of

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addiction to demerol made it necessary to control its sale and it is at present only available to mothers in Britain under a doctor's prescription, though a midwife is allowed to give it when acting on instructions from a doctor.

Twilight Sleep

The term "twilight sleep" is applied to a method of relief in childbirth which includes the use of hyoscine with a pain-relieving agent, originally morphine. By this method not only pain but the memory of pain is abolished from the mother's mind. The great disadvantage of this method, however, is that the mother's cooperation is often lost and delivery by instruments becomes necessary. Also the baby may be born in a condition of asphyxia. A modification of "twilight sleep," combining demerol and hyoscine, has been successfully and safely used in the United Kingdom and America. But demerol is certainly not the last word in pain relief in childbirth; research is continually going on to produce something even safer and more effective.

Later in the first stage and second stage of labor, the needs of the mother alter. She now requires a powerful analgesic which operates intermittently—that is at the height of the contraction of the uterus or "pain." At this time an analgesic which is inhaled by the mother and which she can administer to herself is best. For this the well-known "gas and air" method, invented by Dr. R. J. Minnitt of Liverpool, is widely used, especially as a midwife working alone can use it, provided she has received the special training required. The mother presses a rubber mask on to her face and inhales deeply from the machine which delivers a mixture of 50 per cent nitrous oxide or "laughing gas" and air. The mother cannot suffer from an overdose if the machine is properly used, since if she loses consciousness she releases the mask.

A notable United Kingdom discovery in recent years has been that of trichloroethylene or "trilene." This is a powerful anesthetic, similar in many of its actions to chloroform, and it can be used as a self-administered analgesic for childbirth in a similar way to nitrous oxide.

As a result of a recent trial carried out by Britain's Royal College of Obstetricians and Gynecologists, it was decided that trilene could not be considered safe for the single-handed midwife to administer with its present appliance, as overdosage could result from a change in temperature or from shaking the bottle which contains the liquid trilene. It is probable, however, that current research will shortly solve these difficulties. Trilene is much more portable than gas, which has to be carried in heavy cylinders. It is also non-inflammable.

A committee set up by Britain's Medical Research Council is at present considering the problem of pain relief in childbirth from the standpoint of the midwife and with special reference to the mother who is having her baby at home. Research is being carried out into new drugs and new methods and, though the results are not likely to be available for some time, it is hoped to bring adequate relief within reach of every mother wherever she is confined.

It must be realized, however, that no universal panacea for pain in childbirth exists or is even likely to be discovered. In future it is probable that greater emphasis is likely to be given to natural childbirth and thus lessen the need for artificial relief.

Christmas

The star is a universal symbol—used in many countries. In *Poland*, for instance, Christmas dinner is not served until the evening star shows in the heavens, while from *Alaska* comes an especially interesting custom called "Going Round with the Star." A star-shaped wooden frame is covered with bright tissue paper and for three nights prior to Christmas it is carried from door to door by carol-singing boys and girls.

Nurses' Part in Postnatal Care

HESTER LUSTED

Average reading time — 8 min. 12 sec.

THE AIM OF all postnatal care is twofold: first, to ensure the satisfactory return of the mother to her normal health and vigor; second, to ensure adequate care for the newborn infant so that he may develop normally, remain free from disease, and establish satisfactory behavior patterns. We must recognize the importance of each of these distinct yet interrelated aspects of the situation if we are to achieve good postnatal care for every mother.

In considering the nurse's part in postnatal care we tend to think of the actual physical care required by mother and baby as the primary need. Actually the fundamental factor is the many adjustments which the mother must make during this period in order to successfully do her combination job of mother, wife, and homemaker. There is no more critical period in family living than the days and weeks immediately after the birth of the baby, particularly a first baby; and no greater opportunity to demonstrate how invaluable good nursing care can be to the patient, the physician, and to the entire community.

Skilful professional care can aid mother, baby, and father so that family ties are strengthened during the postnatal period and the ideal result achieved—a healthy baby with a strong sense of security developing desirable habits and by his contentment reflecting a harmonious home atmosphere with happy parents.

Our part as nurses is to act as a connecting link between physician and family and to assist the mother: (1) with her own care; (2) with the care of her baby; (3) in making the necessary adjustments in her way of living so that the care of the baby can be accomplished without disrupting the entire household.

Many young mothers find it extremely difficult to make these adjustments. It is not uncommon to find that by the time the baby is three weeks old the entire family is upset. The house is untidy, the baby cross and irritable, the mother distracted and tired to the point of exhaustion. There is no plan for any of the daily activities and everything centres about the baby who has developed into a small tyrant. Such an experience can be avoided if the mother realizes the importance and value of a planned routine for her day's work. Where she has had good prenatal supervision she will have learned what the baby's care entails and will know the necessity of having a daily schedule; but without help it takes time to get even carefully made advance plans into operation.

Postnatal care starts before the mother leaves the hospital or is up and about in her own home. She should be taught, following the doctor's orders, to do the few simple exercises that will strengthen the abdominal muscles. In addition she must be warned of the dangers of over-exertion. It is not too early to start talking about how she will manage when she again assumes her place as head of her household. The fact that the mother nowadays is allowed on her feet shortly after delivery may give rise to the erroneous impression that she can immediately return to full activity. This should be avoided by definite plans for help with the essential housekeeping tasks from husband or relatives, or hired household help, so that the mother can care for her baby herself and still get sufficient rest.

Naturally the mother's first concern is the welfare of her baby and

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she feels that the first big task she faces at home is his daily bath. If she can have the best possible nursing assistance at this point many of the difficulties and complications of the later postnatal period can be prevented. Such nursing service may be given on a full-time or part-time basis but it *must* be given by a nurse specially prepared to give postnatal care, one skilled in teaching and counselling.

It is not suggested that only a nurse can give the baby a bath but the skilful nurse uses this occasion as a demonstration of the easiest method of bathing and dressing the baby. As soon as the mother wishes, and feels strong enough, she bathes the baby herself with the nurse present to guide and encourage her in learning this new skill. The nurse should not consider her care to mother and baby adequate until she assures herself that the mother can handle the baby with assurance and to the mutual satisfaction of both.

To the mother the bathing of the baby is the outstanding accomplishment during the first few days at home. To the nurse the vital point is the opportunity it gives her to establish a good relationship with the mother and advise her concerning innumerable details of the baby's daily routine and her own health. The well-qualified nurse anticipates many questions of which the mother is hardly aware and, by teaching her something of the development of the baby, prepares her to handle each new situation as it arises.

What does the inexperienced mother know about nursing her own infant? Someone should teach her very carefully the first time the baby goes to the breast or she will feel bewildered and frustrated with a consequent poor effect on lactation. If she knows that her baby only gets colostrum at first, that it acts as a laxative for him and that, until the milk supply is established, he should only nurse a few minutes to stimulate the breasts, she is prepared to enjoy this new experience.

Another important point is to teach her how and why her nipples should be protected from infection. The period of engorgement should be explained and that the baby may have difficulty grasping and sucking the nipple when the breasts are firm. Most new mothers think that at this stage they have too much milk—if they realized that they probably secrete less than eight ounces they would not feel discouraged or alarmed that the baby is not satisfied with breast alone. Often a supplemental feeding is prescribed without explaining to the mother the best method of using this. Without her understanding, it soon acts as a substitute. She may have no knowledge of the many ways in which milk can be stimulated; if, in addition, she believes that a baby only cries when hungry she will answer this "demand" with more food and before the 10th day the baby will be weaned and her breasts never have a chance to work up to that daily 16 ounces that is normal by the 10th day.

So often we hear a mother say, "I tried so hard to nurse my baby but after the first week or two I had to wean him." If she understood how her breasts functioned would she consider the first week a fair trial? Between the 5th and the 10th day, when the milk supply can double itself, the mother is getting home with her baby, learning to care for him, and gradually increasing her own activity. Nursing care that is "caring" can help her make breast feeding a successful and satisfying experience instead of a failure.

Nursing care should not end after the first few days at home are successfully past. The mother needs periodic visits for supervision until she is able to take her baby out to the doctor's office or to a Well Baby Clinic. If she has had the V.O.N. service, weekly visits are made till the baby is six weeks of age. If other nursing service has been given periodic visits can be made by a nurse from the City Health Department. During these visits the nurse observes the health of the mother and baby and encourages the mother to practise teaching that has already been given. At each visit the

nurse guides the mother in handling new phases of the baby's growth and behavior.

The importance of the post-partum examination is emphasized for, if the mother is feeling well and has not been previously convinced of its value, she may neglect to return for this check-up. The nurse also stresses the value of medical supervision for the baby, either by a private physician or clinic. By explaining the need for immunization the nurse prepares the mother to expect this health protection for her child. The intelligent mother usually has many questions to ask regarding the growth and development of her baby and by giving her an understanding of normal processes the nurse helps to lay the foundation for a stable family life.

Most of these remarks have applied particularly to the mother who is a young primipara. If the mother is an older primipara these same problems of adjustment will likely be intensified because her pattern of living is well established without a baby. If husband and wife have been anxious for a child for a long period they may be so oversolicitous in their care as to upset the baby.

Where the mother is a multipara she returns to the responsibility of the other children's care. She may not need as much teaching regarding the care of the new baby but she does need help and a review of the latest methods. If the preschool children have not been prepared for the new baby, she may have behavior problems to deal with and overt displays of jealousy. The nurse in bathing the new baby can do a great deal toward solving such problems.

As a member of a profession every nurse has a responsibility to the community in addition to her responsibility to her patient and to the physician, and this responsibility should include the promotion of adequate maternity care for every mother and potential mother in the community. The nurse herself may not be participating in a maternity program but even so she has many contacts with prospective parents in the course of her daily activities. These contacts provide opportunities to inform them regarding safe and adequate maternity care.

Generally speaking the public places unlimited confidence in a professional nurse and if we are to demonstrate that such confidence is not misplaced we must keep ourselves well informed and alert to provide information.

At the very least every nurse should know where the patient can get the service she needs, whether this service is provided by hospital or by public health organizations. It is our responsibility to educate the community to make full use of the available facilities for nursing care. This is only possible through full cooperation between nurses in all fields.

Canadian Red Cross Society

The following are recent staff changes in the Provincial Divisions of the Canadian Red Cross Society:

British Columbia—APPOINTMENTS: *Mrs. Jean Haines* (Royal Columbian Hosp., New Westminster) to Edgewood. RESIGNATIONS: *Edwina Buchan* from Edgewood; *E. Floren* from Terrace to be married; *Mrs. Jane Spencer* from Lillooet.

Ontario—APPOINTMENTS: *Dorothy Chapman* to Armstrong after taking public health course. TRANSFERS: *Oda Hansen* to Hornepayne; *Mildred Harton* to Mindemoya; *Amy Hayward* from Nipigon to Richard's Landing; *Winona Inches* from Emo to Bancroft; *Madge McFarlane* to Englehart; *Peggy Parker* from Emo to Rainy River; *Margery Rilett* from Port Loring to Kakabeka Falls; *Helen White* from Dryden to Nipigon. RESIGNATIONS: *Eulalie Brown* from Emo to go to University of Toronto; *Barbara Chrysler* from Richard's Landing to be married; *Ruth P. Gillies* from Haliburton; *Dorothy Hall* from Dryden; *Gaetane Larocque* from Apsley to go to University of Ottawa; *Wilma Lippert* from Matachewan to be married; *Mary Nickel* from New Liskeard; *Mrs. Lucy Shaw* from Huntsville; *Ella Sommerfield* from Apsley.

Breast Feeding

HILARY B. BOURNE, M.D., C.M.

Average reading time — 9 min. 36 sec.

THE PURPOSE of this article is not to convey any particular scientific data but rather to remind members of the nursing profession that breasts were supplied for the specific role of suckling the newborn.

The first visible evidence of the formation of mammary glands is recognizable in embryos during the second month of development. It is usually during the sixth week that a pair of band-like thickenings make their appearance along the ventrolateral body-walls from the axillary to the inguinal regions. These are the so-called "milk lines" and it is from these that the mammary glands arise. In the human species the mammary glands as a rule develop within rather narrow limits of the pectoral regions, but not infrequently supernumerary nipples may occur at other levels along the course of the milk lines.

Histologically and developmentally, the mammary gland suggests somewhat a sweat gland. In the resting stage each gland is composed of 15 to 25 closely adjoining, irregular lobes radiating from the nipple. These are separated from one another by layers of connective tissue and much fatty tissue. Each lobe is provided with a duct, the "lactiferous duct," which runs towards and opens on the nipple. Each duct under the areola, the pigmented area surrounding the nipple, has a local dilatation, the "lactiferous sinus," which becomes constricted again and, curving upwards towards the surface of the skin, opens at the summit of the nipple as an independent opening. In essence, the mammary glandular tissue may be likened to a bunch of grapes with the grapes being the secreting portions and the stems representing the duct system. In between the grapes and stems lies the connective tissue and the quantity of fatty tissue which is responsible for the contour and great bulk of the breast. It is easy to realize, therefore, that the size of the breast gives no indication of the amount of glandular tissue.

The physiology of the mammary glands is interesting but complex and as yet not clearly or definitely understood. Suffice it to say, however, that the ovarian and pituitary gland hormones seem to be responsible for its development to full maturity and functional activity while the stimulation of the nipple produced by the act of suckling creates a reflex nervous mechanism that maintains the secretory activity.

It is a well-known fact that the worst place in the world as regards breast feeding is the United States; Canada runs a close second. It is also well known that the European, and in particular the Scandinavian, countries are best in this regard. The difference, however, is not due to geographical location, or anatomical development, or even physiological insufficiency. The great difference is one of temperament, education, and so-called modern living. The North American woman of today is not sufficiently impressed during her adolescent years of the importance and advantages offered by breast feeding. She is rather inclined to think the opposite because all her older friends who are married and new parents are using the bottle and one of the many powdered milks which are so beautifully advertised in journals—medical and otherwise. Moreover, she does not have time to breast feed and, in particular, she is unable to go to the movies or social functions because she has to be at home at the time of the next feeding. There are a

Dr. Bourne is a physician in the Department of Obstetrics and Gynecology, Royal Victoria Hospital, Montreal.

multitude of other reasons put forward by our women of today. We, however, must not confer the entire blame on the "mothers." We as doctors are also partly responsible. We are far too lenient in our efforts to convince the antenatal woman that she should at least have a try at breast feeding when the baby arrives.

Breast feeding is the natural way to feed the newborn infant. Nature made this provision purposely and also arranged for the production and flow of colostrum during the first two or three days after delivery, superseded by milk. The function of colostrum is apparently twofold: (1) To act as a catharsis and thereby free the alimentary tract of meconium, and (2) to provide a source of euglobulin, the only protein that newborn babies do not have in their blood and the protein which is associated with antibodies. These protective antibodies are, therefore, transferred from the mother in high concentration and accordingly afford the baby a better capacity to resist infection in early life. This may be the all-important reason why infant mortality is lower among successfully breast-fed infants. Famulener in 1912 said that it is most highly desirable that every newborn infant should receive its full ration of human colostrum.

The milk which eventually replaces the colostrum is well known to you both physically and chemically and is specially suited to the needs of the baby. Apparently human milk changes somewhat in composition as time goes by and the baby becomes older. There is no substitute for human milk. We can, however, approximate it very closely and with artificial feeding achieve wonderful results. But all of us are agreed that artificial feeding should be resorted to *only when natural breast feeding is a complete failure.* If the mother can supply as much as half the baby's requirements, then it is worth both the time and trouble to breast feed and supplement. Not only does the baby benefit but also the mother. It is well recognized clinically that the return to normal anatomical size and position of her pelvic organs is greatly facilitated by the act of nursing. This is apparently a reflex nervous phenomenon originating in the nipple.

The success or failure of breast feeding depends to a large extent on the quality of the antenatal care. By this, I mean, that the doctor should not think of the pelvic organs alone and leave the breasts to the charge of the nursing staff. Instead it should be his bounden duty to impress upon the patient, particularly if she is a primipara, the importance of caring for her breasts throughout her pregnancy and the undoubted good which her baby will obtain from nursing. One must appeal to the emotional or, perhaps more correctly, the maternal instincts of the new mother-to-be and prepare her mentally so that by the time the baby is delivered she accepts the idea calmly and rather looks forward to the nursing. That the emotional reaction of the mother will govern in part the degree of success or failure of nursing is well shown in cows which, if disturbed emotionally, will desist from giving their usual abundance of flow. The patient should be instructed to pay particular attention to the nipple area and should the physical examination reveal any abnormality of the part, such as inversion, proper measures should be adopted to counteract the defect.

In the later months of pregnancy special attention should be paid to the cleanliness of the nipple. Daily washing to remove the scum of collected secretions, followed by the application of ordinary vaseline to prevent crust formation and to soften the nipple, is imperative. These points are stressed because they have great practical value. When the baby is put to the breast he instinctively opens his mouth widely and takes himself a mouthful. The suction which follows causes the nipple to advance towards the pharynx and come to rest between the base of the tongue and the soft palate. His gums and/or lips are thereby situated around the lacteal sinuses which are a short

distance behind the base of the nipple. By squeezing with his gums the lacteal sinuses are compressed and milk is literally forced out of the nipple. Note that the milk is not sucked out of the nipple, at least not forcibly, for it is impossible to exert much suction on an object situated between the base of the tongue and the soft palate. The nipple, therefore, is not subjected to much stress and trauma is correspondingly much less. If the above, which is the natural procedure, does not occur and the nipple lies between the gums, then the baby actually chews at the nipple and in a very short time a break in the surface occurs. This in turn leads to two conditions: (1) sore nipples, the pain of which is not infrequently excruciating, and (2) infection, with its dire consequences.

Our duty is obviously to prevent such a complication and this is best accomplished by following what has already been suggested for the antenatal period. Cleanliness of the nipples, the use of glass shields for any defect in the proper eversion of the nipples, and the use of an agent, such as vaseline, to soften them and the surrounding areola and skin, are measures that will save a great deal of worry in the puerperium. The elasticity of the nipple area is an important factor in allowing the nipple to advance to the soft palate region. Any condition, therefore, which hinders this will lead to trouble —for example, inelasticity, marked engorgement of the breast with edema of the skin, thereby preventing the baby from getting a proper grasp on the breast, and inversion of nipples.

During the lactating period a few complications may develop. The most common are sore nipples, engorgement, and infection, in that order of frequency. The first is the result of poor antenatal preparation and poor technique on the part of the mother. It is astonishing how few primiparas and even multiparas know how to nurse correctly. When the baby is put to the breast he receives a mouthful of milk which causes him to choke and gulp thereby frightening the mother who pulls away from the baby and thereafter offers only the nipple. The baby then chews on the nipple and the ultimate result is soreness and abrasion. This abrasion is a source of infection which sometimes ensues. It is, therefore, imperative that all nurses should know these facts and enlighten the mother. Engorgement is the result of filling of the breasts with milk and incomplete emptying. They become full, heavy, overloaded, and unyielding, and the newborn does not get nourishment in the amount it needs. It is a discomforting condition but is not serious and can quite easily be treated. Infection is usually a sequel to "cracked nipples" and offers a minor problem.

Contraindications to breast feeding are few and seldom arise. Chronic infections, such as tuberculosis, acute infections of any kind, maternal debilitation, and perhaps cases of erythroblastosis are about the only ones. The last mentioned is not definite as yet but is being practised at this hospital because of the fear of transferring antibodies from the mother as indicated above. It should be pointed out that Cesarean section is no contraindication to breast feeding unless of course the mother is having a stormy post-operative recovery.

There are many other simple facts regarding the benefits of breast feeding but it will be evident from the above that nurses and doctors are the ones to encourage breast feeding because they know without doubt that:

1. There is no substitute for breast milk.
2. The mother benefits physically.
3. Fewer successfully breast-fed infants die than those fed with artificial milk.
4. "Anemia of infancy" is not uncommon and cow's milk contains less iron than does human milk.
5. The mother who has the milk and good nipples actually has less trouble than if she were using a formula.

Our efforts should not end with mere encouragement. We should demonstrate and insist on the prenatal care referred to above.

A Mother Breast Feeds her Baby

M. Doris Anderson

Average reading time — 4 min. 6 sec.

During the past year we, of the Maternity Pavilion of the Vancouver General Hospital, have been changing our procedures for nursing mothers. Our aim is to ensure good lactation with maximum comfort and enjoyment. The results have been so gratifying that we hope that those interested in promoting breast feeding will consider the following suggestions.

The primipara, during the first day postpartum, nurses her baby on each breast for one minute, every three or four hours according to the needs of the baby. During the second day, she nurses her baby on each breast for two minutes, and so on, increasing one minute at each breast each day until a ten-minute period on each breast is reached. Some babies are quite satisfied after nursing for five or six minutes on each breast. With the multipara, the milk usually comes in more quickly so that the nursing time can be increased accordingly. Each mother is instructed to start the baby on the breast from which he finished the previous time. If he finished from the right breast at ten, he begins from the right breast at two and from the left at six. This prevents his always draining the same breast when he is more hungry and partially emptying the other one when he is more satisfied. It is of the utmost importance that the mother be in a comfortable position for nursing and that she be encouraged by all with whom she comes in contact.

With twins, for the first few days, each baby is put to the breast singly at each feeding, but when nursing satisfactorily they are put to the breast simultaneously. The mother sits up in bed with two pillows placed diagonally across her lap and the babies are placed under her arms with heads forward and legs behind, leaving the mother's hands free to assist as necessary.

For the premature baby, the mother pumps her breast with a hand or an electric pump, according to the needs of the individual case, five times during the 24 hours. Later, when her breasts are sufficiently soft she is taught to express the milk manually. The massage incidental to this procedure aids in stimulating the milk supply. Recently a mother sent in 40 ounces of milk daily for her premature twins.

In cases of late lactation, when it is necessary to give a complementary formula, this should be kept to the minimum amount. Sometimes a little given after the evening feedings is sufficient.

The mother should be taught the symptoms of overfeeding, which are: crying after the feeding, colic, chewing the fists, diarrhea, and vomiting in spite of a good milk supply and a gain in weight. The treatment is to shorten the nursing time or to feed the baby on one breast only, at one feeding time.

The milk supply can be increased in a number of ways. The mother

Miss Anderson is nursery supervisor in the maternity department of the Vancouver General Hospital.

can drink more milk and water. She can take brewer's yeast. She can stimulate the breasts by emptying them completely by hand after the baby has nursed. This milk can be given to the baby as a complementary feeding after the next nursing. She can also stimulate the blood supply to the breasts by bathing them in hot and cold water alternately and finishing with a brisk but gentle massage.

Mothers are unanimous in their approval of this method because, apart from having very little trouble with nipples and being relieved of the feeling of lopsidedness, they are successfully breast feeding their babies and enjoying it.

The following is the record of Baby Wendy born in this department on October 15, weight 8 pounds 6 ounces, discharged on October 21, weight 8 pounds 5 ounces. The mother brought the baby to the follow-up clinic.

October 31: Weight 8 pounds 6 ounces. Symptoms of overfeeding present. Mother worrying. Weighed before and after one feeding—gain 8 ounces. The mother was instructed to nurse the baby for five minutes only on each breast.

November 7: Weight 9 pounds—gain of 10 ounces during week. Symptoms of overfeeding still present. Buttocks red. The mother was instructed to give the baby one ounce of boiled water before the feedings.

November 14: Weight 9 pounds 14 ounces. Gain of 14 ounces during week. Water not given because the baby did not like it. Buttocks slightly red. Condition improving. The mother was instructed to apply paste to the buttocks, not to give water and not to worry.

November 28: Weight 11 pounds 4 ounces. Gain of 22 ounces during two weeks.

Condition excellent. Discharged from the follow-up clinic to attend the Child Health Centre.

The mother nursed Baby Wendy according to the routine noted above. She had an excellent supply of milk and overfed the baby but, with instruction and encouragement, the symptoms of overfeeding disappeared. At the age of about a month and a half the baby had gained nearly three pounds and was a very happy bright child.

Christmas

Santa is known by many names: Père Noël (Father Christmas) in *France;* Kris Kringle in *Germany* (from Christ Kindl or Christ Child); St. Nicholas in *Belgium.* In *Iceland* Santa comes in the form of a tiny elf and, though *Syrian* children have no Santa Claus, they know of a tiny camel that accompanied the Wise Men. They leave bowls of grain and water outside their doors for this weary little traveller and, there as here, the good children find gifts on Christmas morning.

Educational Secretary Wanted

With a busy program of national importance before it, in the development of far-reaching educational projects, including the evaluation of schools of nursing in Canada, the Executive Committee of the C.N.A. is searching for a nurse with the right academic qualifications and sufficient experience to enable her to undertake this work with confidence. The minimum salary offered is $4,000 per annum.

The Executive Committee is interested also in finding an *Assistant Secretary* for the staff at National Office. No specific requirements have been laid down but, all things being considered, preference will no doubt be given to an applicant having superior academic qualifications, plus sufficient experience to enable her to undertake the detailed and varied secretarial work which this position requires. The minimum salary being offered for the Assistant Secretary is $3,000 per annum.

The cooperation of the nurses of Canada in presenting applications for these two important positions is urged. Applications should be directed to **Miss Gertrude M. Hall, General Secretary, Canadian Nurses' Association, 1411 Crescent St., Montreal 25, Que.**

"Hamlet" on the Maternity Ward

EPILOGUE

I could a tale unfold whose lightest word
Would harrow up thy soul.

Act I, Scene 5

Whose sore task
Does not divide the Sunday from the week.

Act I, Scene 1

7:30 A.M. REPORTS

In . . . all things will we show our duty.

Act I, Scene 2

CASE ROOM

There's a divinity that shapes our ends.

Act V, Scene 2

WARD WORK

Frailty, thy name is woman!

Act I, Scene 2

If there be any good thing to be done,
That may to thee do ease, and grace to me,
Speak to me.

Act I, Scene 1

ROUNDS BY THE CHIEF OF STAFF

I shall not look upon his like again.

Act I, Scene 2

It is a custom
More honour'd in the breach than the observance.

Act I, Scene 4

TIME OFF

Take thy fair hour . . . time be thine,
And thy best graces spend it at thy will!

Act I, Scene 2

VISITORS

A little more than kin, and less than kind.

Act I, Scene 2

4:00 P.M.

To pan, or not to pan,—that is the question:—
Whether 'twere better in the economy of time
To ask the visitor to pace the hall
While nature is attended to, or wait;—
To wait! perchance they'll ring; ay, there's the rub;
Just when the supper trays come down the hall
Or when a summons from the case room comes
Or when the lusty babe with squalling haste
Demands attention.

(with apologies) *Act III, Scene 1*

Though this be madness, yet there is method in't.

Act II, Scene 2

7:00 P.M. REPORTS

Sit down awhile,
And let us once again assail your ears,
That are so fortified against our story.

Act I, Scene 1

ANY FATHER TO HIS SON

Good-night, sweet prince.

Act V, Scene 2

ONE NURSE PUTTING 25 PATIENTS TO BED

This sweaty haste
Doth make the night joint-labourer with the day.

Act I, Scene 1

MIDNIGHT

For this relief much thanks.

Act I, Scene 1

Get thee to bed.

Act I, Scene 1

12:30-3:00 A.M.

The nights are wholesome.

Act I, Scene 1

For some must watch, while some must sleep.

Act III, Scene 2

And whatsoever else shall hap to-night,
Give it an understanding, but no tongue.

Act I, Scene 2

5:00 A.M. PANS

The time . . . out of joint.

Act I, Scene 5

The lady protests too much, methinks.

Act III, Scene 2

7:00 A.M. TEMPERATURES

My pulse, as yours, doth temperately keep time.

Act III, Scene 4

7:30 A.M.

O heavy burden!

Act III, Scene 1

Fain would I beguile the tedious day with sleep.

Act III, Scene 2

PROLOGUE

O heart, lose not thy nature; let not ever
The soul of Nero enter this firm bosom.

Act III, Scene 2

Assume a virtue, if you have it not.

Act III, Scene 4

And flights of angels sing thee to thy rest!

Act V, Scene 2

—ANONYMOUS

Lyle Creelman *Writes* . . .

Average reading time — 5 min. 12 sec.

ONE OF THE THINGS which makes living in Geneva so very interesting occurred recently. We attended a buffet supper given by Miss Marguerite Pohek, of the European Office of the United Nations Social Affairs Department, for 32 United Nations fellows. These students were from 16 countries and along with the extra guests 23 nationalities were represented. The fellows have very wide interests in the welfare field: industrial and child welfare, social insurance, rural welfare, delinquency, rehabilitation of the disabled, welfare of the blind and the deaf, etc. After a week of orientation in Geneva they will go to the United Kingdom for six months and will each have the opportunity of studying what is being done in their respective area of interest. The seven from Malaya will remain for two years, however, and will be studying at the London School of Economics.

A most interesting member of the group was Miss Kyniaki Kanelli from Greece, a totally blind girl travelling completely on her own. While in Geneva the Malayan group has accepted her as their special responsibility. Naturally her main interest is in blind children and she wants to find out what is being done in England so that she can return to help in the organization of their new school in Salonika. Her face brightens when she talks of her wish to learn more about what can be done for children who have never seen; she herself had sight until she was seven.

Five women from India among the group wore their colorful saris and the Malayan women were also in native costume. Those of us in ordinary western clothes were envious.

* * *

My friend, Helen Martikainen, and I have just returned from two weeks' leave in the south of France. We left our car at Hyères on the mainland and, after a short boat trip, reached the delightful, undeveloped Ile de Porquerolles. It is one of a group of three islands, sometimes referred to as the Iles d'Or and, judging from the beautiful sunsets which we beheld in the evenings, we can easily understand why it was thus named.

This island is about five miles long and two to three miles wide. Parts of it are cultivated with vineyards and olive groves but mostly it is wild and rocky with pine trees and cliffs rising high above the sea. There are many beaches, the most popular of which is the Plage d'Argent which truly is a beach of silvery sand. Needless to say we spent many hours basking in the sunshine. We also explored the island from one end to the other and found the remains of several forts used in times past for protection against possible invaders. Between 1940 and 1945 the island was occupied by three foreign groups—first Italians, then Germans, and finally Americans. There were few English-speaking visitors apart from ourselves and we welcomed the opportunity to practise our halting French.

On our return we spent a few hours in the interesting city of Avignon. It is surrounded by a wall and inside is the famous Palais des Papes described by a French writer as "la plus belle et la plus forte maison du monde." This was the home of the Popes for the greater part of the fourteenth century.

Only part of the famous bridge of Avignon is standing. As we stood by the river to photograph the bridge a woman came down to the water to do her washing. This practice interested us in passing through the French villages in this part of the country. There seemed to be a communal laundry consisting of a large cement tank with a pump or tap at one end. It was divided, making sec-

tions for washing and for rinsing. We saw small ones and large ones and at the latter several women were busily soaping and rubbing their clothes. That makes washing time a really social gathering!

It was the season of the grape harvest. In the vineyards the luscious green and purple grapes were being picked and loaded into small horse- or donkey-drawn carts and taken to the winery to be made into the famous French wines.

We spent the night at the Hôtel Relais de l'Empereur in Montelimar. This was a favorite stopping-place for Napoleon. It has, of course, been renovated since his time but it still retains a delightful atmosphere of age and historical interest. The cuisine is excellent and I hardly need to say that both here and at Porquerolles we enjoyed immensely this feature of our French holiday.

* * *

To return to nursing—many of you will know Nancy Toy and Mary Harling. Nancy is from Brantford and has recently been working with the Child Health Association of Montreal. She is now in New Delhi, India, and is organizing the clinical teaching of pediatrics in the Irwin Hospital in cooperation with the New Delhi College of Nursing. In case you don't know already, the college gives a degree in nursing and this year their first four students graduated.

Mary Harling, from Montreal, was an instructor at the Montreal General Hospital. We interested her in going to Penang, Malaya, where, along with three other WHO nurses, she is assisting in the development of the educational program of the school of nursing. When she was in Geneva we had a delightful week-end trip to Chamonix which nestles at the foot of Mont Blanc. Mary was introduced to her first *téléférique* ride and she seemed to enjoy it thoroughly. On our way back we passed through some delightful French and Swiss villages and in the photograph you will see her standing beside a fountain in one of them. You may know that in this part of the world every little hamlet has its fountain which, in the summer, is gay with flowers.

MARY HARLING

Cradle Song

O My deir hert, young Jesus sweit,
Prepare thy creddil in my spreit,
And I sall rock thee in my hert
And never mair from thee depart.

But I sall praise thee evermoir
With sangis sweit unto thy gloir;
The knees of my hert sall I bow,
And sing that richt *Balulalow!*

—ANONYMOUS (*16th Century*)

Nursing Profiles

Muriel Archibald has assumed her duties as secretary-registrar and school of nursing adviser with the Association of Nurses of Prince Edward Island, a newly created position which followed the coming into effect of the new Nurses' Act in that province this year.

Miss Archibald has had excellent preparation for both the administrative aspects of her work and also the school of nursing activities. Born in Nova Scotia, Miss Archibald's preliminary education was received in Halifax and Charlottetown. She graduated from the Toronto General Hospital in 1930 and spent the following three years in private nursing in that city. A couple of years as matron of a private hospital in Trinidad preceded her enrolment in the course in teaching and administration in schools of nursing at the University of Toronto. Experience as an instructor followed at All Saints', Springhill, N.S., Jeffery Hale's in Quebec City, and Homoeopathic Hospital, Montreal. In 1948, she went to the position she has just vacated at the National Office of the Canadian Nurses' Association as the statistical worker. Miss Archibald's chief delights are her car and modelling in clay. She should have the opportunity of indulging in both these hobbies in Charlottetown.

MURIEL ARCHIBALD

Hazel Bernice Keeler has returned to her native province of Saskatchewan as director of the School of Nursing, University of Saskatchewan. This appointment is particularly appropriate in view of Miss Keeler's extensive experience in university work since the program is to be considerably revamped to include specialized training in public health nursing or in teaching and supervision within the five-year course. Heretofore, Saskatchewan nurses have had to go outside their own province for the extra year's training.

Miss Keeler had already secured her B.A. from the University of Saskatchewan before she commenced her training at the Vancouver General Hospital in 1929. She received her certificate in teaching and supervision from the McGill School for Graduate Nurses in 1935 and five years later her M.A. from Teachers College. Her first position as a graduate nurse was as obstetrical supervisor at the Kootenay Lake General Hospital, Nelson, B.C. For four years she was science instructor in her own school of nursing, going from there to be clinical supervisor at the University Hospital, Edmonton. Following her work in New York, Miss Keeler was director of nurses at the Women's College Hospital in Toronto. In 1943 she undertook the organization of the School of Nursing Education, University of Manitoba. Since 1948 she has been on the faculty of the University of Buffalo. We shall watch with interest the development of these new courses under her gifted leadership.

Esquire Photo, Saskatoon

HAZEL B. KEELER

Janet Christina MacKay, R.R.C., is the new president of the Nursing Sisters' Association of Canada. Presently superintendent of nurses at the Lachine General Hospital, Que., Miss MacKay graduated from the Royal Victoria Hospital, Montreal, in 1923. She held head nurseships there until her enlistment with the R.C.A.M.C. in 1940. She served in England for two years as nursing sister in charge of the operating theatre with the Montreal Neurological Unit. Returning to Canada she was head of the operating room at the Rideau Military Hospital, Ottawa, for one year before becoming assistant matron at the Debert (N.S.) Military Hospital. For some time prior to her discharge from the services, Major MacKay was principal matron of the military district in New Brunswick. She was awarded the Royal Red Cross in 1944.

Miss MacKay is currently president of the Alumnae Association of the Royal Victoria Hospital. She is a member of the Soldiers Memorial Chapter of the I.O.D.E., Lachine. A busy person with many diversions, Miss MacKay brings outstanding qualities of leadership to her new role.

JANET C. MACKAY

Orma Jacklin Smith is pioneering a new position as adviser to schools of nursing in Alberta under the egis of the University of Alberta. Born in Saskatchewan, Miss Smith graduated in arts from the university there, receiving her professional training at the Vancouver General Hospital. Staff work for two years in the hospital at Burns Lake, B.C., was followed by her appointment as matron of the Enderby (B.C.) Hospital. Postgraduate work at the Toronto Psychiatric Hospital and a year as a head nurse in the private pavilion of the Vancouver General Hospital preceded Miss Smith's enlistment with the South African Military Nursing Service. Soon after she received her discharge three years later, she enrolled in the course in administration in schools of nursing at the McGill School for Graduate Nurses. She later was appointed superintendent of nurses at the Galt Hospital, Lethbridge, Alta. More recently she was director of nurses and principal of the school of nursing at the Saint John General Hospital, N.B. Miss Smith will strengthen the present provincial nursing education program as she goes from school to school, as well as in her course of lectures at the university.

ORMA J. SMITH

Margaret MacKenzie, who for 30 years has been superintendent of the nursing services of the Department of Public Health, Nova Scotia, has retired. A native of Middle River, Victoria County, N.S., Miss MacKenzie received her professional training at the Victoria General Hospital, Halifax. She served overseas with the C.A.M.C. during World War I for four years. Following her return to Canada in 1919, she enrolled in the public health course at the University of Toronto School of Nursing, joining the department the following year. During her career the public health nursing service in Nova Scotia has grown from a few municipal nurses into an organization of 35 provincial nurses.

Miss MacKenzie was honored on the occasion of her retirement at a special ceremony held in the Office of the Minister of Health. At that time presentations were

Halifax Herald Ltd.

MARGARET MACKENZIE

made on behalf of the office and field staff. She retires with the good wishes of all her friends and associates. She plans to travel and renew old acquaintances before settling down in her home in Halifax.

Evelyn Kessler has undertaken an interesting piece of work at the Jewish General Hospital, Montreal. She is the new director of nurses and is completing plans for the opening of a school of nursing in conjunction with that hospital in the near future.

All Miss Kessler's previous nursing experience has been in the United States. A graduate of St. Elizabeth Hospital, Utica, N.Y., in 1934, she began as a staff nurse at the Willard Parker Hospital in New York City and worked up to the post of educational director nine years later. She secured her B.S. degree in nursing education in 1944. For the past three years Miss Kessler has been coordinator of instruction for Dillard University student nurses at Charity Hospital, New Orleans, La.

EVELYN KESSLER

Dame Ellen Musson, D.B.E., R.R.C., LL.D.

The Council of the Royal College of Nursing would place on record their appreciation of the work of Dame Ellen Musson, member of Council since 1919 and Honorary Treasurer during the years 1938-50, thereby expressing their gratitude for the wisdom and skill which she brought to bear upon their deliberations and for the great service which she rendered as Honorary Treasurer, especially during the difficult post-war years.

They would refer particularly to those special gifts through which, as a woman, a nurse, and an administrator, she brought great distinction to the profession she served. As a matron, councillor, and chairman of the General Nursing Council (1926-44), her professional knowledge, her learning, and legal attitude of mind made her an outstanding figure in her generation.

They are proud to feel that these qualities have been nationally recognized. In 1932 the University of Leeds conferred upon her the honorary degree of LL.D. and in 1939 His Majesty the King made her a Dame Commander of the Most Excellent Order of the British Empire. Internationally Dame Ellen Musson is recognized as one of the great influences in British nursing.

In paying tribute to Dame Ellen's qualities with affection and gratitude the Council would wish her much happiness and tranquillity in her years of retirement.

—Minutes of the Council

Old age, especially an honored old age, has so much authority, that this is of more value than all the pleasures of youth.—CICERO.

Public Health Nursing

Care of "His Majesty"

LOUISE P. BELL

Average reading time — 7 min. 6 sec.

EVERY MOTHER knows two basic rules of baby care: scrupulous cleanliness and clocklike regularity. The new baby must be protected from all contamination as completely as possible until such time as he is old enough to have built up resistance to harmful bacteria. Therefore, he should be kept immaculately clean and sweet and so should every one of the tiny garments used on and around him. All should meet hygienic standards. "His Majesty" should, of course, also be on a regular feeding, bathing, and sleeping schedule, for these things help to make and keep him healthy.

He should be bathed daily, at least one hour after feeding. Most mothers find that morning is the logical time for this. Until the cord has separated and the umbilicus entirely healed, a sponge bath is the order of the day, with good soaping, rinsing, and drying the three steps. He should be kept covered as much as possible during these sponge baths so no drafts will strike his tiny body.

When the umbilicus is entirely healed, tub baths may be given. A bathinette is a great convenience or, as a substitute, set a small tub on a low stool or table. Half fill it with tepid water—warm but not hot to the elbow. Lay baby on a table over a folded towel and wash and dry his face with clear water—no soap. Then with well-lathered wash cloth of the very softest material you can find, start to wash baby's head carefully. If a scale appears, oil baby's scalp at night with sweet oil, then soap thoroughly, wash with warm water and dry gently next morning. If the condition does not clear up after two or three such treatments, speak to the doctor about it. Now undress baby and, while he is still on the table, sponge his body all over with a soapy wash cloth. Lift baby from the table and place in the tub feet first.

Remember that a tiny baby can be easily frightened by rough handling, loud noises, and the feeling of being dropped. So hold him gently and talk to him softly as you lower him into the tub. Put your left arm and hand under his head and shoulders, grasping his left arm at the shoulder so as to hold him securely. With your right hand, grasp his feet and legs. Once he is in the tub the right hand can be freed to soap and rinse off his little body. Pay particular attention to the arm-pits, neck, and groin. Using both your hands, lift baby from the tub to the table and wrap him in a large soft turkish towel. Pat baby dry with the towel and smooth a little sweet oil in the soft, tender folds and creases or dust lightly with baby powder. The infant's nose and ears are best cleansed with a piece of soft absorbent cotton. The inside of the mouth should not be touched and baby's eyes should not be washed unless the doctor orders it.

CARE OF BABY'S CLOTHES

There are two things to consider in choosing baby's clothes: first, baby's comfort and protection; second, mother's time and energy in caring for baby's clothing. The more simple the clothing the better, so choose garments that are well designed, easy to put on and take off, and easy to wash for baby's clothes must be dainty, fresh, and clean at all times. Smooth absorbent diapers add to his comfort. Knitted lightweight cotton nightgowns are easy

to wash and require no ironing. Flannelette blankets are useful to wrap about baby and protect the wool blankets from becoming soiled quickly.

If you use a diaper laundry service, the diaper problem is solved. If you don't then be sure to have an adequate supply (three to four dozen) and get some of those paper diaper liners to tuck inside—they save lots of needless work. Diapers should be washed separately from other clothing, whether in a washing machine or by hand. As soon as they are taken off, they should be put to soak in a cold water-borax solution in a covered pail until they can be washed in hot soap-suds. Use a plunger or a small washboard if washing them by hand. Give diapers at least three thorough rinsings and hang them outdoors in the sunshine to dry. Once a week, boil them for about 15 minutes in clear water after rinsing. Occasionally, bleach the diapers if you dry them indoors. Use the bleach sparingly and follow the manufacturer's directions. Do not iron diapers. Just hang straight on the line and fold smoothly when dry.

Cottons need no special handling. Just wash them in warm soap-suds, rinse well, and dry outdoors. Iron only the prettiest, on-parade garments. Nightgowns, bands, and bibs need only be straightened as they are taken from the line. Baby's cotton quilted pads are washed in plenty of hot soap-suds, rinsed well, and allowed plenty of time for drying.

Baby's little woollies can be kept soft and in good shape if they are washed with care, using lukewarm suds, quick and gentle squeezing, several short washes in clean suds rather than one prolonged washing, and three gentle rinsings in lukewarm water. Press out the final rinse water carefully and remove further moisture by rolling the garment in a turkish towel, then shake out. If possible, dry sweaters, knitted caps, and woollen stockings on adjustable forms; or take the measurements of the woollies before washing and dry them on a flat surface, easing carefully to shape and size. Never dry baby's woollens in the sunlight or intense heat or cold. Bonnets may be dried over a padded bowl.

Follow the same washing procedure for silks and rayons as you use for woollies. Measuring is not necessary but when these are almost dry press on the wrong side with a moderate iron.

Babies' blankets should be washed often. The secret of washing blankets so that they retain their original softness and fluffiness lies in the use of plenty of tepid soap-suds, very careful handling, and proper drying. It is advisable to give blankets a three-minute run if washing them in a machine. Then rinse well in lukewarm water and run the blankets through a loose wringer. Hang evenly over the clothes-line to dry in a warm airy place. When partly dry, press out water that collects in the corners and pull the edges gently to shape. The same principles should be observed when washing blankets by hand—plenty of lukewarm suds, careful handling, and proper drying.

Since every baby dribbles fruit juice or cod liver oil on his clothes at one time or another, it is well to know the easiest way to take out these stains. "Immediately" is the word for the treatment. If they are allowed to stand, they become "set" and are either difficult or impossible to get rid of. For fruit juice stains on white cottons, try the old trick of pouring boiling water from a height through the stains, then wash in warm soap-suds as usual. Treat cod liver oil stains by laundering immediately. If a brown stain remains, you might try bleaching white cottons with peroxide, then rinse out bleach at once. Egg-stained cotton or linen should be soaked for a while in cold water than laundered.

By degrees the comforting light of what you may actually do and be in an imperfect world will shine close to you and all around you, more and more. It is this that will lead you, never to perfection, but always toward it.—JAMES LANE ALLEN

Institutional Nursing

Puerperal Inversion of the Uterus

WALLARD S. HOLMES, M.D.

Average reading time — 4 min. 12 sec.

MRS. EADES, a primigravida 22 years old, was delivered precipitately in a neighboring nurses' home on her way to the Saskatoon City Hospital on November 3. Her calculated date was November 20.

A physician was summoned from a nearby village and arrived within an hour or so to find the placenta undelivered. The third stage of labor was accompanied by excessive bleeding, associated apparently with failure of the placenta to separate normally. The physician returned to the patient the next day and left orders with the nurse in charge for supportive treatment, also some sulfonamide for her fever.

On November 6, three days postpartum, the patient was brought by ambulance to the Saskatoon City Hospital. On arrival the hemoglobin was 22 and red blood cell count 1,190,000. The blood pressure was 100/56, temperature 102.6°, and pulse 120. She was not bleeding and nothing extraordinary was noted on inspection, apart from evidences of anemia. No vaginal examination was made. The fundus uteri could not be felt through the abdominal wall. The patient had difficulty urinating.

A transfusion of 500 cc. of citrated blood was given the evening of admission and this was repeated the next day. Penicillin, 20,000 units, was given intramuscularly every three hours and ferrous sulphate, gr. 5 t.i.d. p.c., was administered. The iron, food, and fluids were taken well by the patient, who felt well enough to ask about getting out of bed three days later.

Dr. Holmes is chief obstetrician at the Saskatoon City Hospital.

On November 10, four days after admission, when the temperature had fallen to 100° and the pulse was 100, the patient began to bleed quite profusely. She was prepared and taken to the operating room for curettage on the basis of a diagnosis of retained secundines. When examined under pentothal sodium anesthetic, the vagina was found to contain the everted uterus which completely filled the vagina but did not protrude from it. A plaque of placental tissue was adherent to the everted fundus. This tissue was removed and, after exploring the vagina, an attempt was made to replace the uterus manually. The patient became deeply shocked, however, so no further manipulation was done. Plasma, glucose, and blood were given intravenously and the patient was sent back to her ward. Three days later, after more blood had been given and with the patient much improved generally (Hb. 48, R.B.C.2, 660,000, W.B.C. 9,000.), she was taken back to the operating room and, under a low spinal anesthetic, the uterus was ultimately replaced by gentle persistent compression until its bulk was reduced sufficiently to permit gradual replacement, pressure being made upward at the cervical rim, so that the portion to evert last was replaced first. This manoeuvre was invented by Charles White in 1773. It took about one hour. The patient withstood the manipulation well. The uterine cavity was then packed tightly with gauze, which was removed the next day.

Blood was given during the operative procedure and afterwards. The temperature and pulse became normal about the 6th day after replacement of the uterus and the patient was

discharged November 22, 16 days after admission with a hb. of 57 and R.B.C. 3,230,000. She had had a total of approximately 3,300 cc. of citrated blood.

At the postnatal examination on December 17, no general nor pelvic abnormalities were noted. She brought her nine-pound baby along.

Puerperal inversion of the uterus is said to be the rarest obstetrical complication. While it occurs spontaneously, it probably results more often from forceful efforts to remove a placenta adherent to the fundus by pressure on the fundus uteri through the abdominal wall and/or traction on the umbilical cord. Shock and hemorrhage always accompany this catastrophe, the former being proportionately more severe than the latter.

Where this complication of the third stage of labor is suspected, a vaginal examination is indicated, since an everted uterus may not be exteriorized and the diagnosis, therefore, delayed. Immediate replacement of the everted uterus by manual aid is the procedure of choice. The liberal use of blood and plasma cannot be over-emphasized.

In the Good Old Days

(*The Canadian Nurse, December 1910*)

"About a month ago the directors of the Winnipeg General Hospital, being anxious that the institution should attain to the fullest possible measure of usefulness, decided to establish a social service department."

* * *

"Provincial registration would do a great deal towards raising the educational standard of the nursing profession, as it would mean a standard would be set for all training schools to adopt, and no nurse would be able to call herself a registered nurse unless she had passed the examination set by the Board of Registration. It would also protect the public against the so-called experienced nurse who calls herself a trained or graduate nurse and charges the same fees as a nurse who has given three years of hard, earnest work and study for her diploma."

* * *

"When we state that fully one-third of the nurses in New York City today are Canadians we are making a very conservative estimate . . . Why do Canadian nurses come here and stay here? In Canada one hears continually of the high salaries paid to professional people, especially nurses, in New York. Why is it that we hear so very little about the higher cost of registration, of laundry, of room rent, and of board? If the higher cost of living were as well known as salaries, it would make a difference."

* * *

"Miss Bella Crosby . . . has now been appointed Editor of *The Canadian Nurse* by the Editorial Board. She will enter on her new duties at once and the first number of Volume Seven (January, 1911) will be issued under her direction."

* * *

The graduates of the Stratford General Hospital Training School for Nurses have formed an alumnae association . . . Graduates from other schools residing in Stratford will be admitted as Associate Members and the third-year nurses-in-training will be admitted as Privileged Members, having the privilege of attending regular meetings and taking part in discussions, but may not vote or hold office.

If you're not serving a holiday punch, you may prefer to fill your bowl with figs and raisins and walnuts and sweets—the traditional "end" of any Christmas dinner. In so doing, you are following, in part, an old *Greek* custom called "The Luck of Christmas," for Greek youngsters go out on Christmas morning to collect the same figs and raisins and walnuts and sweets that crown our holiday tables.

Aux Infirmières Canadiennes-Françaises

Aperçu sur le Service Social à l'Assistance Maternelle

FERNANDE VERRET

Average reading time — 15 min. 36 sec.

AU SERVICE d'hygiène et médical de l'Assistance Maternelle de Québec, comme dans bien d'autres services, la période récente a été marquée par un vaste effort pour l'application des techniques du service social. Les difficultés et les problèmes rencontrés chez les patientes ont créé, en effet, le besoin, la nécessité d'appliquer ces théories.

Avant d'entrer dans le vif du sujet, je rappellerai brièvement le but de cet organisme qui est d'aider à diminuer la mortalité maternelle et infantile chez-nous, en procurant gratuitement aux futures mères peu fortunées les consultations prénatales, les services et soins du médecin et de l'infirmière lors de l'accouchement à domicile et durant les suites de couches. Pour celles qui doivent être hospitalisées, un lit est retenu pour elles à l'hôpital. En plus, des médicaments prescrits, le service distribue le lait, la layette, et la literie.

En 1948, pour répondre à une demande faite par l'université, une clinique d'enseignement obstétrical a été organisée, c'est-à-dire que les finissants en médecine assistent aux cliniques de consultations prénatales et ils accompagnent le médecin aux accouchements.

Si nous reconnaissons qu'il existe des maux d'ordre physique ou psychique, il faut admettre qu'il existe aussi des maux d'ordre économique, social, familial et émotionnel. Nous avons tous journellement de multiples problèmes à résoudre, malgré la vie relativement normale que nous menons. Que dire alors des miséreux, des inadaptés, des mécontents, et des révoltés? Si nous voulons atteindre notre but—favoriser une maternité plus heureuse, contribuer au bien-être de la mère et de son enfant—nous ne devons pas ignorer ces aspects dans une clinique prénatale. En un mot, tout programme de santé qui a pour but de promouvoir la santé de la mère et de celle de son enfant ne doit pas négliger l'importance des facteurs économiques, sociaux, familiaux, et émotionnels en fonction de leurs vies et de leur bien-être présent et futur. Si nous reconnaissons ces facteurs dont l'influence se fait également sentir sur la vie de l'enfant et si nous essayons de satisfaire aux besoins de la future mère, nous contribuons hautement non seulement au bien-être de celle-ci, mais nous assurons aussi au nouveau-né les avantages d'une bonne santé à la naissance et les possibilités quasi assurées que lorsqu'il atteindra sa maturité on pourra le classer parmi les adultes bien adaptés.

Nul n'ignore, en effet, que les impressions créées chez un enfant durant les six premières années de son existence peuvent avoir une influence capitale dont il ressentira les effets le reste de sa vie.

Voilà pourquoi le médecin, l'infirmière, et l'assistante sociale constituent une équipe qui cherche à réaliser de meilleures conditions sociales et ce travail d'équipe est essentiel pour atteindre l'objectif fixé.

Toutefois, ce service social dans une

Mlle Verret est directrice du Placement Familial, Cité de Québec.

clinique prénatale doit prendre une physionomie particulière en fonction des difficultés de la femme enceinte, des cadres du service et du milieu.

Le service social, en plus de la science et des techniques que ce travail exige, c'est avant tout quelque chose de profondément humain qu'on peut appeller l'amour raisonné de son prochain auquel il faut venir en aide en l'acceptant tel qu'il est, tel qu'on le trouve, et non tel que nous voudrions qu'il soit. L'essence même du service social c'est d'avoir, de posséder à un haut degré le sens social. Ce sens social se caractérise surtout par une tournure d'esprit particulière, compréhensive, une attitude sympathique mais constructive envers les personnes avec lesquelles nous traitons.

Si vous le voulez bien, nous jetterons ensemble un coup d'oeil sur le travail accompli et susceptible d'être accompli en tenant compte de tous les facteurs déjà mentionnés. Or, dans une clinique comme la nôtre, l'on attache une grande importance à la première entrevue de la patiente soit avec l'infirmière, soit avec l'infirmière assistante-sociale. Qui nierait l'influence exercée sur nous par une première impression? La personne même la plus objective n'en est pas exempte; les psychologues l'avouent, l'expérience le prouve, et tous le proclament. Ce sont toutes des futures mères qui se présentent au service; cependant, combien différentes elles sont! Elles confirment sans contredit la loi naturelle d'individualisation. Quelques-unes d'entre elles sont ignorantes, naïves, ou imbues de préjugés; d'autres nerveuses, d'autres phlegmatiques, d'autres bien avariés par une misère physiologique ou morale qui se trahit par des caractéristiques non équivoques. D'autres, par contre, s'attendent à tout, car elles ont déjà tout subi; d'autres encore sont révoltées et insatisfaites. Il y a aussi un certain nombre de patientes qui semblent équilibrées et peu compliquées. La plupart cependant ont ceci en commun: "la crainte." A quoi doivent-elles s'attendre de nos services? Réaction incontestablement généralisée chez un grand nombre d'humains. Ce sentiment est plus accentué ici, à cause du préjugé d'une fausse impression et croyant qu'elles auront des services moindres que ceux donnés chez le médecin privé, en raison du fait que nos services sont gratuits.

De la première entrevue dépend l'acceptation par les patientes des conseils, soins, et services qu'on lui offre. Que vient chercher cette personne au service, qu'attend-elle de nous?—une aide financière, de la sympathie, une compréhension amicale, des directives? Tout cela et même davantage. En somme, il faut tenter de refaire une partie de son éducation, lui démontrer l'importance et la nécessité des consultations périodiques avec le médecin; lui indiquer la ligne de conduite à suivre en regard du régime de vie, de l'alimentation, etc. Il est de toute évidence que de cette première rencontre dépend le succès du but à atteindre et auquel seule la discipline que s'imposera la future mère peut assurer. Il faut que la patiente se rende compte de la nécessité des examens préconisés pour elle et pour son enfant, qu'elle sache le pourquoi des soins donnés, du régime, et de l'alimentation imposée par sa condition. La patiente est dispensée, lors de son inscription, d'un questionnaire fastidieux. Celui-ci, me direz-vous, est nécessaire. C'est exact, mais il doit se faire sous la forme d'une conversation amicale et au cours de laquelle on doit noter les faits essentiels quant à l'histoire médicale et sociale.

On évite ainsi de blesser la patiente, en l'obligeant dès cette première entrevue, à étaler soit sa pauvreté, son désarroi moral, ou sa misère. L'expérience a démontré que cette méthode donne des résultats pratiques qui permettent d'obtenir tous les renseignements indispensables. N'est-il pas vrai qu'on évite un ami aux questions indiscrètes et que souvent on se confie plus facilement à ceux qui semblent moins anxieux de connaître nos problèmes personnels? A nous de constater et de vérifier par la suite si nos observations sont précises et bien fondées.

Au Point de Vue Economique

Tous admettent qu'il y a des familles moins bien partagées les unes que les autres. C'est précisément dans ce milieu que nous évoluons. Or, il faut intervenir auprès des services sociaux déjà existants afin qu'on procure à ces personnes la nourriture, le chauffage, les vêtements, et même faire les frais du loyer dans certains cas. Dans d'autres cas, il faut aussi intervenir afin d'obtenir des pensions et il faut même les administrer lorsque le chef de famille s'avère incapable de le faire. De plus, lorsque des patientes doivent-être hospitalisées et pour lesquelles il est difficile de demander les secours de l'assistance publique, soit que leur cas ne se conforme pas aux exigences de la loi de l'assistance publique, soit en raison d'une naissance qui crée l'impression d'être prématurée ou pour toute autre complication. Ces patientes peuvent donc grâce à notre organisme bénéficier de conditions spéciales pour l'hospitalisation.

Au Point de Vue Emotionnel

Presque toutes les futures mères, et particulièrement celles que nous traitons, sentent le besoin et l'opportunité de s'extérioriser. Cette réaction émotive se traduit généralement par le désir d'exprimer ses inquiétudes, d'être écoutée, d'être comprise, d'être orientée. Si cette réaction est refoulée, elle peut déclancher de l'anxiété dont les effets seront aussi funestes pour la santé de la mère que pour celle de l'enfant.

De plus, la future mère doit savoir qu'il ne suffit pas simplement de donner à manger, de garder au chaud le petit pour répondre à ses besoins. Elle doit lui procurer, dès sa plus tendre enfance, l'affection dont il a besoin. Cette affection peut déterminer et influencer dans une large mesure l'adaptation de l'enfant aux différentes périodes de sa vie. L'attitude des parents envers la venue de l'enfant peut avoir également une influence heureuse ou malheureuse sur toute la vie de ce dernier. Bref, un bon nombre de futures mères ne sont pas prêtes émotionnellement à remplir le rôle de mère. Elles ont fréquemment le sentiment que les responsabilités nouvelles seront plus grandes que les joies que leur procurera le nouveau-venu.

Certains Facteurs Sociaux

Le milieu, l'attitude erronnée de parents, d'amis, l'accumulation de préjugés et de superstitions envers les soins prénataux entravent, influencent, et retiennent même quelquefois la future mère à l'écart des soins préconisés.

Nous devons donc assurer dans nos cliniques un service d'une courtoisie attachante, devenir la confidente des patientes, leur éviter les longues heures d'attente, et surtout ne jamais brusquer ces personnes qui sont généralement plus susceptibles que leurs soeurs plus fortunées que nous rencontrons chez le médecin privé.

Pour toutes ces raisons, il faut donc s'efforcer de remédier à certaines lacunes; écouter celles qui éprouvent un véritable soulagement à raconter leurs déboires, leurs scrupules, et qui espèrent recevoir une directive, une opinion qui les aideront à sortir du dilemme où les a enfermé leur inexpérience de la vie ou très souvent une éducation faussée. Il faut tenter de créer chez ces personnes une certaine indépendance rationnelle qui les aidera à réaliser l'épanouissement de leur personnalité et à atteindre leur maturité d'esprit.

Ce travail préliminaire se complète souvent d'un travail d'interprétation de normes et de principes fondamentaux oubliés et méconnus tels que: la nécessité du travail, la stabilité au travail, la solidarité qui doit exister au sein de la famille, etc. En un mot, c'est un travail de rappel aux lois naturelles auxquelles nous ne pouvons nous soustraire sans causer le désordre et le malheur. Il faut aussi essayer d'apporter une solution aux problèmes de personnalité, de mésentente conjugale, due maintes fois à l'ingérence d'une belle-mère, à la jalousie, ou à la crainte de maternités trop souvent répétées.

Dans un grand nombre de cas de personnes désemparées, il suffit d'ap-

porter une thérapie de support, de compréhension, de rectification d'attitudes, et de jugement.

Bref, la science, la compétence, la compréhension, la patience, et la bonté doivent être les instruments de toutes celles qui aspirent à jouer un rôle dans les services sociaux.

Wrapping Your Christmas Parcels

PACKAGES—gay and varied, colorfully wrapped and ribbon-tied—are, for many of us, the visible symbol of the gay and festive spirit that is in the air, everywhere, at Yuletide. Your packages can really be "something to talk about" this year. You needn't be limited by the traditional red and green combination—good as that always is—for many new papers, new ribbons, and new colors are now available.

A new fluorescent ribbon, to be had this year in bright glowing tones, has a special finish which gives a luminous sheen. When used with the new dark papers, or those with a suede-like surface, you will achieve a package that is very 1950 in appearance. Then, too, there are the latest versions of the glittery tinsels and metallic ribbons, the shiny satins, and timely printed ones. These, together with the rich foil papers, lovely plain-colored ones, and others telling the Christmas story in pictures, all are designed to help you make your packages extra special.

Ribbon Guild, Inc., New York
You can do it too!

Choose ribbons that will blend or contrast with your paper. For instance, a moss-green ribbon on a gold-papered box becomes more exciting by the addition of a touch of flaming tangerine. Cerise and white bows on pale blue paper; a lemon-yellow ribbon tied around a dark green package, with scarlet for accent; or lime and brown ribbons on paper of a coppery tone indicate some of the more unusual ways in which to use color.

To make lovely packages, you need not tie yourself into knots—either literally or figuratively. The ability to wrap packages beautifully is not the prerogative of any one small group—it is a skill that can be mastered by all of us—and here's how . . .

Wrap it—and tie it: Clear an adequate working space—flat, firm, and with plenty of elbow-room. Assemble all your equipment: scissors, seals, glue, ribbons, papers, boxes, etc. Wrap your gift in fresh tissue and place it in a box of proper size. If the paper has a pattern, be sure you so place the box that the design will be well spaced on the top. Fold paper over, pull smooth and taut, fold ends neatly and fasten with scotch tape or decorative seals. If box is large, tape two sheets of paper together and proceed as you would with a single sheet. The seams may be concealed with ribbon. Two different colors, or a printed paper combined with a plain one, will produce a novelty effect.

And make a bow: No matter how you

(*continued on page 993*)

Trends in Nursing

Average reading time — 7 min. 36 sec.

The Canadian Way

THE JOINT PLANNING COMMISSION on Adult Education tried out something new in discussion leadership at the spring conference this year. Three observers of the Canadian scene were asked to speak, at the opening of the session, on the general question of the big ideas about which all member bodies should be concerned. The main message of the three speakers was that member organizations should be more concerned with understanding Canada's position in world affairs and the working of Canadian democracy. They intimated that many Canadian education agencies went about their business almost unaware of the fact that our relationships with other countries are of the utmost daily importance to each of us. They suggested that we seem inclined to accept the existence of Canadian democracy in a mildly stupid sort of way, failing to understand just how and why it works and not realizing that circumstances could snatch it away from us. The Joint Planning Commission was convinced that the two big ideas to be recommended for study in the coming year are: (1) the Canadian economy in relation to world affairs; (2) the problems of Canadian democracy.

—*Food for Thought*, Oct. 1950.

Fact Finding

A sickness survey being conducted by the Saskatchewan Public Health Department, in cooperation with Ottawa authorities, started September 1, Malcolm G. Taylor, director of the department's Research and Statistics Branch, has announced. The survey will be national in scope and has been initiated by the Department of National Health and Welfare and the Dominion Bureau of Statistics.

In each province, including Saskatchewan, a number of urban communities and rural areas have been selected as samples, representative of the entire population, Dr. Taylor said. The survey will take in 21 farming areas.

In Saskatchewan, enumerators are under the supervision of Miss K. Stephen, Regina, and the information-gathering will be conducted for one year, with monthly visits to households. Information to be sought will include environmental factors in sickness, such as housing, water supply, food preserving, and heating; individual illness; and money actually spent on health services, including medical care, dental care, hospitalization, drugs and appliances. All information obtained will be treated confidentially and the analyses will be done by the Dominion Bureau of Statistics at Ottawa.

The survey is intended to provide the federal and provincial health authorities with valuable information as a basis for extension of preventive services and health insurance planning.

—*Saskatchewan News*, Sept. 1950.

International Standards

A major achievement in international cooperation received suitable recognition as the Third World Health Assembly adopted unanimously for world use a set of 39 international standards for biological substances, among them standards for vitamins, vaccines, sera, antibiotics, and other products. Standardization of these substances for international use started under the League of Nations Health Organization and is being continued by the World Health Organization.

—*WHO Newsletter*, June-July, 1950.

International Pharmacopeia

The English version of the first International Pharmacopeia, contain-

ing descriptions of some 200 drugs in general use, is now completed. Prepared by the WHO Expert Committee on the Unification of Pharmacopeias, it will probably be published in a French and a Spanish edition as well before the end of 1950.

—*WHO Newsletter*, June-July, 1950.

Register of Refugee Nurses

Many nurses have been found among the masses of people who fled their countries during and after the war and who eventually came under the care of United Nations through its specialized agencies.

The International Refugee Organization assembled a Professional Nurses Screening Board to interview these persons and to establish the professional status of those who claimed to be qualified nurses. Members of this board were nurse representatives of their countries who had been leaders in their profession.

The board compiled a register of professional nurses which has been particularly valuable to individual nurses, nurse registration boards, and prospective employers. Many nurses who might have been lost to the profession have been re-established in nursing work after their professional status was determined. The nursing profession, also, is protected.

In order that this service may be continued, an agreement has been reached to transfer this Displaced Persons Professional Register to the International Council of Nurses. Alice Sher, assistant executive secretary, who is president of the Nurses Screening Board, will be responsible for this program which will include: (a) providing professional advice to nurses in past or present refugee status; (b) establishing professional status of the individual nurses; (c) amending the nurses' register.

—*American Journal of Nursing*, Aug. 1950, p. 478.

International Classifications

The French and Spanish editions of the "WHO Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death" have recently been published and are now on sale at all booksellers carrying WHO publications as well as at the Palais des Nations, Geneva. The Manual, which first appeared last year in English, is designed to ensure as far as possible uniformity and comparability of health statistics. It provides for the first time a single method for reporting both diseases and causes of death and is, therefore, of invaluable assistance to hospitals, clinics, social security administrations and insurance companies.

Educational Workshops

Many nurses met at Vina del Mar, Chile, under the auspices of PASB and the Government of Chile for an educational workshop dealing with problems in administration, supervision and teaching methods in nursing education and public health nursing.

The purpose of the workshop was to help participants find solutions to problems arising in their everyday work through study, discussions, and interchange of ideas. Meetings of small groups permitted participants to uncover problems which they wished to study more fully. Individual consultation was also given on special problems by the members of the teaching staff, representing all aspects of nursing education and public health nursing.

—*WHO Newsletter*, Aug.-Sept. 1950.

Appraisal of Nursing Care Needed

We have found . . . that traditions and outmoded procedures play an important part in present-day nursing care, consuming valuable nursing time. We have estimated that roughly 128,000 nursing hours, or the time of 63 full-time nurses, are spent each year in Indiana hospitals providing care in the obstetrical service that is unnecessary, while many essential jobs are left undone. This indicates a need for the evaluation of present

nursing care, the adjustment of policies and procedures, and the development of a plan to meet present-day patient and hospital needs.—L. E. BURNEY, M.D.

—*A.J.N.*, July, 1950, p. 409.

Professional Accreditation

Marion Sheahan, director of programs for the National Committee for the Improvement of Nursing Services, spoke of the areas in which this committee will work. Major emphasis for the immediate future will be placed on professional accreditation of all nursing schools eligible for such accreditation. Another step is toward the improvement of nursing services through improvement of nursing service administration. Basic to these, she said, is an information program for the development of professional relationships which will bring about better understanding of the program by nurses, other professional and allied groups, and government agencies.

—*A.J.N.*, Sept. 1950, p. 577.

Clinical Instruction

A challenging article on this topic by Joan H. Bourne appears in *Nursing Times*, July 22, 1950 (p. 750). Miss Bourne explores her subject critically and from many angles. While citing experiences gained in Canada and particularly at the School of Nursing, University of Toronto, she emphasizes the need to adapt the program to the particular situation. A short article follows on page 763 entitled "Clinical Teaching in a Norwegian Hospital" and is by Aagot Lindstrom, Ulleval Hospital, Oslo. Both of these articles express a point of view that might well repay consideration.

Orientation et Tendances en Nursing

Et au Canada

Le Comité d'Organisation pour l'Education des Adultes a inauguré un nouveau genre de discussion. Trois observateurs de la vie canadienne furent invités à adresser la parole à la séance d'ouverture sur un sujet de leur choix, lequel, néanmoins, devait intéresser tous les groupes faisant partie de l'association pour l'éducation des adultes. Les trois conférenciers furent unanimes à conseiller aux groupes intéressés à étudier davantage la position du Canada dans les affaires du monde et la démocratie canadienne.

Ces conférenciers insinuèrent que des associations s'occupant de l'éducation des adultes faisaient leur travail presque sans se rendre compte que nos rapports avec les autres pays ont une importance qui se fait sentir tous les jours dans la vie de chacun. Nous faisons la bêtise, dirent-ils, d'accepter la démocratie canadienne comme une chose telle quelle, sans savoir au juste comment elle fonctionne et sans réaliser que dans certaines circonstances elle pourrait nous être enlevée.

Le programme de l'année prochaine comprendra ces deux idées importantes: (1) l'économie canadienne en relation des affaires internationales; (2) le problème de la démocratie canadienne.—*Food for Thought*, oct. 1950.

Des Faits

C'est sur les maladies que portera l'enquête qui sera faite par le Ministère de la Santé Publique de la Saskatchewan, en coopération des autorités fédérales. L'enquête sera sur une base nationale et a été commencée par le Département National de la Recherche et le Bureau Fédéral de la Statistique. Dans chaque province, la Saskatchewan comprise, un nombre de centres urbains et de centres ruraux ont été choisis comme centre d'échantillonnage de la population totale de la province. L'enquête portera sur 21 centres agricoles. L'observation durera un an et comprendra une visite mensuelle à chaque famille. On cherchera des informations sur le milieu, sur les facteurs pouvant avoir une influence sur la maladie—tel que, le logement, l'approvisionnement de l'eau, la conservation des aliments, le mode de chauffage; les maladies

individuelles; argents actuellement dépensés dans les services de santé, comprenant les soins en maladie, le soin des dents, l'hospitalisation, médicaments, etc. Toutes les informations obtenues seront confidentielles et l'analyse en sera faite par le Bureau Fédéral de la Statistique à Ottawa.

Cette enquête a pour but de fournir aux gouvernements fédéral et provinciaux des renseignements précieux, lesquels serviront à l'extension des services préventifs de santé et dans la préparation des plans d'assurance.—*Saskatchewan News*, sept. 1950.

Enfin! Des Normes Internationales

Des normes internationales pour les produits biologiques, vitamines, vaccins, sérums, etc., ont été adoptées à la Troisième Assemblée de Santé Mondiale. La standardisation de ces produits, pour en faciliter l'usage à travers le monde, a été commencée par le Service de Santé des Nations Unies et achevée par l'Organisation Mondiale de Santé.

Une Pharmacopée Internationale

La première pharmacopée internationale, version anglaise, vient d'être complétée. Elle contient plus de 200 médicaments d'usage courant. Préparée par un comité d'experts, cette unification de diverses pharmacopée sera probablement publiée en français et en espagnol d'ici la fin de l'année.—*WHO Newsletter*, juin-juillet, 1950.

Classification des Maladies

Un autre travail important réalisé par O.M.S. a été la publication en français et en espagnol d'un manuel de classification internationale des maladies, des accidents, et des causes de décès. Ce manuel est en vente dans toutes les librairies qui vendent les publications de O.M.S.

Ce manuel, publié l'an dernier en anglais, a pour but d'établir une uniformité qui permettra d'établir des comparaisons dans les statistiques de santé. Cette publication est appelée à rendre de grands services aux hôpitaux, aux administrations d'assurances sociales, comme aux compagnies d'assurances en général.

Foyer d'Étude au Chili

Un groupe d'infirmières du Chili ont tenu des foyers d'étude, sous les auspices du gouvernement du Chili et de la P.A.S.B. Durant ces journées d'étude, des problèmes concernant l'administration, la surveillance et les méthodes d'enseignement dans l'éducation des infirmières et en hygiène publique ont été étudiés. En plus, des discussions et des échanges d'idées entre petits groupes et des consultations individuelles furent données par les consultantes sur tous les aspects de l'éducation des étudiantes infirmières et sur l'hygiène publique.—*WHO Newsletter*, août-sept. 1950.

La Valeur des Soins aux Malades

La tradition joue un grand rôle dans les soins donnés aux malades; certaines techniques aussi démodées qu'inutiles sont encore employées. Dans des hôpitaux d'Indiana, l'on a estimé que 128,000 heures de soins, donnés dans un service d'obstétrique par 63 infirmières, sont d'une part inutiles et d'autre part des soins nécessaires ne sont pas donnés. Cela demande la nécessité d'analyser et d'évaluer les soins donnés par les infirmières et d'adopter des techniques et une ligne de conduite plus en rapport avec les besoins actuels.—*A.J.N.*, juillet, 1950, p. 409.

Accréditation des Écoles d'Infirmières aux États-Unis

Le comité, formé pour l'amélioration des services aux malades, a mis en tête de son programme l'accréditation des écoles d'infirmières, nous communiquait Mlle Marion Sheahan, convocatrice. L'amélioration de l'administration de ces services est aussi au programme. D'une égale importance est un programme d'information ayant pour but de faire mieux comprendre aux infirmières, aux autres professions connexes, et aux services des gouvernements le travail que se propose de faire ce comité.—*A.J.N.* sept. 1950.

L'Enseignement Clinique

Un article, faisant réfléchir, a été publié sur ce sujet dans le *Nursing Times* (juillet 22, 1950, p. 750). L'auteur, Mlle J. H. Bourne, parle de son expérience au Canada et appuie sur la nécessité d'adapter le programme à une situation bien déterminée. Dans le même numéro, à la page 763, on peut lire un court article intitulé "l'Enseignement Clinique dans un Hôpital de Norvège." Les infirmières qui feront une lecture attentive de ces deux articles en retireront de grands bénéfices.

Un Registre pour les Infirmières Venant des Pays Occupés.

Des foules de gens ont dû abandonner leur pays après la guerre et se sont trouvées sous

la protection des Nations Unies. L'Organisation Internationale des Réfugiés a formé un bureau d'examen pour infirmières professionnelles. Ce bureau a été chargé d'interviewer les personnes qui se disaient infirmières professionnelles et d'établir leurs qualifications. Ce bureau était composé d'infirmières des plus compétentes, qui représentaient leur pays respectif.

Le bureau a ouvert un registre d'infirmières professionnelles qui a rendu de grands services—individuellement aux infirmières, aux futurs employés, et aux associations d'infirmières. Sans ce registre, bien des infirmières n'auraient pu établir leurs qualifications et leurs services auraient été perdus pour la société.

Le registre sera transporté au bureau du Conseil International des Infirmières. Le programme du service que le bureau se propose de donner est le suivant: (a) conseils professionnels aux infirmières des pays déplacés; (b) établir les qualifications individuelles des infirmières; (c) améliorer les registres d'infirmières.—*American Journal of Nursing*, août, 1950, p. 478.

Wrapping Your Christmas Parcels

(*concluded from page 988*)

choose to tie the ribbon around the box (crossed through the middle for a square box, crossed at either or both ends for an oblong one, etc.), the *bow* is always made separately and attached to the box later.

To make a big, full bow, use ribbon 2" to 3" wide. Pinch gathers in ribbon about 3" from one end and hold between thumb and forefinger of left hand. With right hand, make a loop about 2" long and pinch in gathers. Continue looping ribbon back and forth, always holding finished loops in left hand, until you have made enough to give the desired fullness. (The narrower the ribbon, the more loops that will be needed.) Tie tightly through centre with wire or ribbonzene. Fluff out loops into a round puff and attach bow to package. About 3 yards of ribbon is required for a nice full bow.

For a tailored, two-toned trimming: Use two contrasting ribbons (print and plain or different colors), each about 1" wide. Place wrong sides of ribbons together and lay flat on table. Make a series of flat loops working back and forth, keeping each loop directly over the one below and a little shorter. Keep centre flat—do not pinch into gathers. Secure to box centre with scotch tape and pin flowers, berries, or an ornament over the centre.

Adding the gingerbread: Little angels, snowmen, animals, etc., may be placed on the package; sprigs of holly or spruce or other greens tucked in with the bow add a seasonal note. Try tying a soft knot near the end of 4 or 5 extra lengths of ribbon. Attach these to the box under the bow so they will fall loosely across package.

Give your packages a fairy touch by the use of "flitter"—a glittering, sand-like material. It comes in red, green, blue, gold, or silver at art or gift shops. It may be used on the ribbons or directly on the package. The parts to be decorated are lightly touched with mucilage, flitter sprinkled on generously, and the excess shaken off. Another way of getting glitter on your packages is to attach small Christmas balls to the ends of the tying ribbons. Remove the cotter pin from the ball, push one end of pin through the edge of the ribbon, and then replace both ends in the ball.

For packages with sound effects, attach small bells to loops of ribbon and string, clothes-line fashion, across the box.

Did you know that metallic and tinsel ribbons will curl? Simply draw the ribbon over the blunt edge of a knife. If you cut 10"-lengths, tie them together in the centre, and curl each end, you will have a fluffy, "curlicue" rosette.

Are round parcels your problem? One answer is to wrap them with aluminum foil—it's very crushable and molds easily to shape. You can tie a big red bow at

one end or dress it up with a ribbon skirt. To make this "skirt," glue lengths of ½"-wide ribbon to a matching band of wider ribbon. Fasten the band around one end so that strips hang to the bottom edge. The more strips, the fuller the skirt. You can attach small bells to some of the strips, to tinkle jovially each time the parcel is lifted. Another way is to roll it in paper. Have the paper longer than the roll and slash the ends to form a fringe. Tie with ribbon bows, and lo! it has turned into a giant party "snapper." If you use plain white paper, wind red ribbon spirally around the cylinder and top with a red Christmas ball—you'll end up with a miniature barber pole.

For the male of the species, omit the frou-frou. If you use bows, make them flat and tailored. Choose masculine colors in both paper and ribbon—browns, dark greens, greys, etc. The package may be decorated with pictures typical of masculine interests, such as sport scenes; or it may be trimmed with gadgets indicative of a particular hobby—i.e., colorful fishing flies, a toy gun, miniature camera, deck of cards, or even bright packages of seeds. For the "strictly business" man, wrap your offering in the financial page of the local paper, tie with gold ribbon, and decorate with play money—bills and coins.

Packages that show care and personal interest will enhance whatever you may give; for any gift means only as much as the thought behind it. Packages can have personality, too—they can be original, and ingenious, and beautiful . . . a compliment to the receiver and a source of pride to you, the giver.

—*Ribbon Guild News*

Treatment for Shock

A group of leading American surgeons has advised the U.S. Public Health Service that salt water taken by mouth, in a vast majority of cases, is as effective as blood plasma in the emergency treatment of shock from serious burns and other injuries.

In general terms, the treatment calls for approximately one level teaspoonful of table salt and one-half teaspoonful of baking soda for each quart of water. A number of quarts are required each day. The only limitation on the amount taken is the ability of the patient to consume the saline solution. Since great thirst accompanies serious burn injury, it has been found that patients will voluntarily swallow a sufficient amount of the solution, which is quite palatable. No other drinking fluid is permitted in the first few days following injury.

In releasing the recommendation, Surgeon General Leonard A. Scheele said: "The findings are of particular importance in a period of war emergency, since it is estimated that in the event of atomic bombing about 60 per cent of the surviving bombed population might suffer from burns. This figure, moreover, does not account for injuries other than burns in which shock also might be present.

"Salt water offers an easy, practical method for the treatment of shock which follows serious burns and other injuries. It is particularly important in any period of large-scale disaster. Unless the patient is disoriented, is in acute collapse, or is among the very small percentage who become nauseated by drinking large quantities of the salt solution, the sodium chloride formula will be effective when administered by mouth."

Dr. Scheele emphasized the fact that treatment by saline solution will in no sense decrease the need for whole blood. Rather, he pointed out, sodium chloride would provide an effective immediate form of treatment which could be administered by anyone.

"The recommendation of the Surgery Study Section, while of enormous benefit in the event of large-scale disaster, must not be construed as lessening in any way the importance of blood bank programs," he said. "Whole blood and plasma are still essential."

—*U.S. Federal Security Agency*

Student Nurses

Hemolytic Disease

RUTH KELLEY

Average reading time — 3 min. 12 sec.

AS STUDENT NURSES we all have opportunities to assist in life-saving procedures but there are times, too, when we must stand helplessly by and see grim death advancing on our charges. It is gratifying to know that each year brings some new weapon with which to fight death and we student nurses owe a great deal to the persevering efforts of research workers. At this time I should like to pay special tribute to the doctors who did the pioneer work on the Rh factor because we had a striking example of the result of their efforts when we watched blood transfusions transform twin babies, who were born with hemolytic disease, commonly spoken of as Rh disease, from weak sickly infants to strong, robust babies.

The mother of those babies had given birth to twins some five years ago. Unfortunately, one of those first twins died during its first year of life. She became pregnant again and on her first prenatal visit was found to have Rh negative blood. Subsequent investigation revealed the fact that her husband had Rh positive blood and was homozygous, which indicated a strong likelihood of her child being born with hemolytic disease. She was watched carefully and it was discovered that this was again a twin pregnancy which fact increased the danger to her babies. Her titer at 30 weeks was free anti-C 1:1; at 36 weeks free anti-D 1:64 with blocking antibodies 1:16.

Preparations were made to have the babies transfused immediately following birth. Through the Red Cross Blood Donor Service replacement transfusion sets were obtained, as was also the blood when it was called for. About two weeks before the expected date of confinement this mother was admitted to our obstetrical department at 7:00 p.m.—not the most desirable time. She went into labor and was delivered of twins, a male and female, about 1:00 a.m. At birth it was noted that the girl baby was very markedly pale with poor muscle tone. The boy baby was in better condition but was obviously affected also. They each weighed approximately six pounds. As their conditions were not considered critical at the moment it was decided to delay transfusing until morning when adequate laboratory work would be more easily available. In the morning specimens of blood taken at time of birth were examined in the laboratory and the correct blood group for each baby was established and blood supplied.

I had the privilege of being "scrub nurse" for this very important procedure and shall tell you about it just as it happened. Each baby was restrained on a circumcision board and placed on a sterile field. We used circumcision sheets for drapes just leaving the cords exposed. A large tank of oxygen was wheeled in and by means of a Y-tube and catheters each baby was given continuous oxygen during the procedure. Fine plastic catheters were threaded without difficulty into the umbilical veins. Using a 20-cc. syringe and a three-way stop-cock 20 cc. of blood were infused and 20 cc. withdrawn until in all 320

Miss Kelley was a senior student nurse at the Charlottetown Hospital, P.E.I., when she prepared this case study.

cc. were withdrawn and 360 cc. infused. A doctor was working with each child and the whole procedure was carried out in one and one-half hours. After each 100 cc. of infusion, 2 cc. of calcium gluconate were given to counteract any tendency to tetany caused by the citrated blood. My part was to cleanse the syringes, stopcocks, and needles in normal saline and keep a clean set on hand for each doctor all the time. We had eight sets in circulation. I was busy!!

The babies experienced no discomfort whatsoever and did not even cry during the procedure. Their immediate conditions were excellent. The boy showed mild jaundice for a few days but became completely clear, fed well, showed adequate weight gain and was discharged with his mother on his eighth day. The girl, however, showed very marked jaundice which gave way to extreme pallor. Her prognosis was somewhat guarded for a few days. Her hemoglobin dropped to 60 per cent and remained at that level for a week. She gradually showed signs of improvement; her hemoglobin increased until on discharge it was approximately 70 per cent. Her general condition was very good. She fed well, appeared bright and active and showed a weight gain better than average. She was discharged when two and one-half weeks old. It was felt that the 360 cc. of blood had not been adequate for the girl baby and her condition would have been much better had she been given 500 cc. However, both babies did very well and it was most gratifying to save them as subsequent pregnancies in this case will in all likelihood terminate in stillborn infants.

Book Reviews

Mental Hygiene in Public Health, by Paul V. Lemkau, M.D. 396 pages. Published by McGraw-Hill Co. of Canada Ltd., 50 York St., Toronto 1. 1949. Price $5.45.

Reviewed by Alice Nicolle, Educational Supervisor, Ontario Division of Public Health Nursing.

Outstandingly practical and stimulating, Dr. Lemkau's book will be welcomed by the many public health nurses who are seeking to improve their understanding of mental hygiene.

Dr. Lemkau is an associate professor of Public Health Administration and director of Mental Hygiene Study in the School of Hygiene and Public Health, Johns Hopkins University. He has used his course in mental hygiene as a basis for the organization of his book which deals primarily with preventive measures and their application in the field of public health. Throughout this broad approach to both the need and the practicability of planning for mental hygiene services, it is assumed that the prevention of maladjustment and mental disease is irrevocably tied up with efforts to prevent other conditions and diseases and as such is a public health responsibility. The author reminds us that "all preventive medicine has as its aim the avoidance of stress on the person at some level of his functioning."

The style of the book is direct and very readable. It is divided into two parts: Part I—The place of mental hygiene in public health; Part II—the development of the individual.

Only in an appendix, and very briefly, is "the classification of the psychopathological states" considered. This sets the book apart from most of the publications relating to mental hygiene. The apparent intention of this brief résumé is to keep before the reader the responsibility of public health workers for the early recognition of deviations from accepted behavior or adjustment and for an understanding cooperation with the psychiatrist.

In Part I, Dr. Lemkau deals with the change in attitude toward mental disease and its treatment, the interdependence of mental hygiene and public health practice, and the idea that methods used in both can be combined in the interest of the individual and his family. As in other diseases and their prevention, "the spread of interest in psychiatry has been from the patient in the institution to the functioning individual in the community."

A chapter is devoted to the discussion of the personality structure as it is affected by environment as well as heredity and the possible results of stresses and struggles on different types of personality. It includes the hopeful note that skilled and trained persons may assist the individual to withstand strain which is not too great and that even the less rugged personality may be helped to develop in spite of adverse conditions. A diagram of personality structure illustrates this theory.

The opportunities open to the generalized public health nurse are clearly recognized by the author—"a ready entry to a cross-section of homes in the community"—the fact that "she is closest to the people" and, therefore, in a strategic position both to recognize and to deal with situations (if she has the preparation) as well as to refer them when they are beyond her ability. Later, on page 193, the school nurse and physician are not so favorably commented upon.

For those interested in existing programs, The Attack on the Problem will provide many suggestions as well as material for comparison. Canadian and United States programs, both remedial and prophylactic, are described in some detail.

Part II of the book deals with an important aspect of mental hygiene of particular interest to the public health nurse. The development of the individual from conception to old age is treated as "a succession of epochs" rather than the usual age ranges, the dividing point being a developmental event such as walking or a sociological event such as beginning school. Each "epoch" is illustrated with everyday occurrences, their interpretation, and some methods of approach. The few individual or family studies are constructive.

A comprehensive bibliography at the end of each chapter and a final list of films relative to each part of the study complete a book which is an important addition to public health literature and deserves a place in every public health library.

How to Turn Ideas into Pictures—A simple method of illustrating publicity and educational materials, by H. E. Kleinschmidt, M.D. 31 pages. Published by National Publicity Council, 257-4th Ave., New York City 10. 1950. Price (in U.S.A.) $1.00.

While some nurses have decided skill as artists most of us feel very inadequate when we try to sketch. We would all agree, however, that one picture may be more descriptive than a thousand words. This being so, the simple instructions, included in this little book, of how to use "visual shorthand" will open up a whole new avenue of approach to the average nurse. Dr. Kleinschmidt says: "Visual shorthand is not art nor drafting but merely a simple code for the transmission of ideas. Anyone who can write can develop the technique, modify it to suit his personality and his illustrating needs—and have fun."

This brief review would be read by everyone if we suddenly reverted to pictures. Maybe we should try! Order your copy and have some fun, too!

Sociology with Social Problems Applied to Nursing, by Sister Leo Marie Preher, O.P., B.A., Ph.D. and Sister M. Eucharista Calvey, O.S.F., R.N., B.A., M.S. 505 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1949. Illustrated. Price $4.40.

Reviewed by Peggy Pike, Instructor of Nurses, Allan Memorial Institute of Psychiatry, Montreal.

The authors divide this book into two parts—the first General Sociology and the second Sociologic Integration in the Field of Nursing. In so doing they attempt to show the close relationship of our environment to our total personality. As the result of this wider concept it is hoped that the nurse of

today will feel even more strongly that "the patient is a human being, of unique personality, and possessing human dignity."

Part I of the book follows the basic pattern of general sociology in a brief simplified form, as found in all sociology textbooks. However, the section on The Family is predominantly based on the Catholic way of life. The first half of this book should be read with a critical eye and used as a basis for discussion rather than a pure textbook.

Part II unites social problems and nursing. Much work has been put forth to provide statistics and charts to illustrate trends in community interest and the results thereof. The writers point out social handicaps of many diseases and follow with suggestions for the nurse in rehabilitating the patient, the family, and in contacting agencies.

This book is a valuable adjunct to a nursing library. However, the idealistic approach throughout must be tempered to the everyday needs and actions of society. At the close of each chapter there is an excellent list of suggested reading which in itself is outstanding.

Materia Medica for Nurses, by Lois Oakes, S.R.N., D.N. and Arnold Bennett, M.P.S. 373 pages. Published by E. & S. Livingstone Ltd., Edinburgh. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 3rd Ed. 1949. Price $2.25.

Reviewed by Sister Mary of Calvary, Director of Nurses, St. Martha's Hospital, Antigonish, N.S.

This book was written in a concise and simple manner so that the student nurse will have an adequate knowledge of the subject in order to intelligently administer the drugs prescribed. This edition presents the latest authentic information regarding the drugs covered. A good list of synonyms is to be found in the Appendix. Chapter XII, Poison Regulations, is very informative and complete. Another favorable point is the Dosage Calculation, which any instructor in this course should find very helpful.

Some important topics which, unfortunately, are omitted from this text are: drug addiction; toxicity and its treatment in connection with the sulfonamides; synthetic and artificial sources of drugs, as well as *detail* in reference to the *action* of drugs.

If the English as well as the Latin terms for drugs were given in the Posological Table (Chapter IV) it would be more meaningful. The section on Common Drugs and Preparations, with their origin, action, and administration, is arranged in alphabetical order instead of in relation to the systems, as is generally found in texts on this subject. Such an arrangement increases the difficulty of presentation. The habit-forming tendency of the barbiturates and narcotics and the nurse's responsibility in this regard are not discussed. No mention is made of the contra-indications for certain drugs to certain patients or under certain conditions.

This book merits recognition among the best reference texts but, because of the omission of valuable pertinent material, it cannot be recommended as a teaching text.

Hospital Administration for Women, by Emily MacManus. 349 pages. Published by Faber & Faber Ltd., London, Eng. Canadian agents: British Book Service (Canada) Ltd., 263 Adelaide St. W., Toronto 1. 2nd Ed. 1949. Price $7.00.

Reviewed by A. L. Thomson, Director of Nursing, Civic Hospital, Peterborough, Ont.

The author is well qualified to write such a textbook from her wide experience and it should prove a valuable reference for any hospital administrator. It particularly deals with the operation of hospitals in Great Britain but there is invaluable material and information about nursing in other countries.

One point is stressed particularly which is worth much consideration on this side of the water and that is the diet peculiar to the different nationalities and its importance in the nursing care of the individual. This point is often overlooked.

At a time when most hospital personnel are on an eight-hour day and a 40- or 44-hour week, it is almost impossible to believe that nurses work as long hours as scheduled in some chapters.

Breakfast served in bed to nurses off duty brought forth a sigh of envy.

Nursing care and comfort of the patient are emphasized throughout the book.

Parkinson's Disease, by Walter Buchler. 79 pages. Published by Walter Buchler, 101 Leeside Cres., London, N.W. 11, Eng. 1950. Price $1.00.

Success stories are not uncommon in current literature. However, when the venture in which the author has achieved success is in learning to live an interesting, vital, and productive life in spite of the affliction of

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paralysis agitans, it is of definite value to nurses.

Patients with advanced Parkinson's Disease, "P.D." as Mr. Buchler calls it, tend to become wholly dependent rather than seeking to develop their own personalities despite their affliction. Mr. Buchler has risen above the physical hindrances and his story of his achievement is offered as a guide to other P.D. patients. So he discusses the ordinary details of living, eating, bathing, etc. He gives sound advice regarding intellectual exercise to keep the mind alert and active even though the body may be sluggish. Courage, resourcefulness, and activity characterize his attack.

This material gives a more exact picture of the disease than most texts. It will be informative for the nurse, helpful for her patients.

In Memoriam

Jane Lawrie Gray, who graduated in 1893 from the Hospital for Sick Children, Toronto, died on September 17, 1950, at the age of 86. Miss Gray had engaged in private nursing and for a time was on the staff of the Hospital for Incurables. She retired from active duty many years ago.

* * *

Pearl (Watson) Hamel, who graduated from Hotel Dieu, Windsor, Ont., in 1916, died suddenly in Monetville, Ont., on September 12, 1950, at the age of 58. Mrs. Hamel served with the U.S. Army Nurse Corps during World War I, subsequently nursing in the United States until her marriage.

* * *

Cora M. Lloyd, who had administered a private hospital in Toronto for a great many years, died in Toronto on September 13, 1950. Born in Ontario, Miss Lloyd graduated from the Flushing (Long Island) General Hospital. She had retired last May.

* * *

Ethel Blanche (Christie) MacLaren, who graduated from McLean Hospital, Waverley, Mass., in 1898, died in Pictou, N.S., on September 20, 1950, after a long illness at the age of 74. Before her marriage, Mrs. MacLaren worked in the United States and in Pictou County.

* * *

Catherine Alice McQuillan, who graduated from St. Joseph's Hospital, Toronto, in 1929, died on September 13, 1950, at the age of 43, following an illness of two months. Miss McQuillan had engaged in private nursing for more than 20 years.

Stella (Ashfield) Shore, a graduate of St. Luke's General Hospital, Ottawa, died recently in Ottawa.

* * *

Dorothy Margaret Stewart, a graduate of the Vancouver General Hospital, died on September 30, 1950. For some time Miss Stewart was matron at Oakalla Prison Farm near Vancouver and later was superintendent at Prince George Hospital.

* * *

Harriet Thomson, who graduated from the Toronto General Hospital in 1895, died on September 19, 1950, in her 91st year. Miss Thomson had served for 35 years as a missionary in India under the auspices of the Presbyterian Church of Canada. She was superintendent of the Central India Mission Hospital for some years.

* * *

Edith (Gillies) Whitaker died on October 1, 1950, at her home in St. Catharines, Ont., in her 49th year. Mrs. Whitaker spent five years in India where her husband was the doctor at a leper colony.

If thou workest at that which is before thee, following right reason, seriously, calmly, vigorously, allowing nothing else to distract thee, but keeping thy divine part pure, as if thou shouldst be bound to give it back immediately; if thou holdest to this, fearing nothing, expecting nothing, but satisfied with thy present activity according to nature, and with heroic truth in every word and sound that thou utterest, thou shalt live happy, and there is no man can prevent it.

—ROMAN EMPEROR, *2,000 years ago*

Cardiac Survivals

Coronary thrombosis, contrary to popular impression, is not usually fatal immediately or within a short time.

Results of a study by Metropolitan Life Insurance Company statisticians show that 70 per cent of a group of persons who had had one or more coronary attacks were still alive at the end of 5 years, 50 percent at the end of 10 years, and 43 per cent at the end of 12 years.

Similarly favorable results were shown among those who were victims of degenerative heart disease but had no record of an acute coronary episode or other complication. Among these the five-year survivorship rate was 72 per cent, the 10-year rate 50 per cent, and the 12-year rate 44 per cent.

Even among cases which had a record of serious kidney or cerebral involvement, the survivorship rate was substantial—40 per cent at the end of 5 years and about 17 per cent at the end of 10 years. Among those with valvular heart disease, 44 per cent were alive at the end of 5 years and 27 per cent at the end of 10 years.

"The results of this study should prove vastly encouraging to many thousands of persons with heart disease, and to their families," the statisticians comment. "A large number of cardiacs can enjoy many years of useful life if they have adequate medical supervision and live within their physical limitations."

—*Metropolitan Information Service*

A man should never be ashamed to own he has been wrong, which is but saying, in other words, that he is wiser today than he was yesterday.—ALEXANDER POPE

In olden times, the *English* had a notion that it was necessary to sweep down the chimney at New Year's in order that good luck could enter the home. Perhaps this is where Santa got the idea. In any case, the chimney is now a familiar Christmas symbol.

Nursing Sisters' Association

During the biennial convention of the Canadian Nurses' Association the *Vancouver Unit* played hostess to all visiting nursing sisters and many reunions took place. On June 30 the biennial meeting was held at Hotel Georgia and during the evening the Unit served refreshments. On July 1 a bus trip across the Second Narrows Bridge and along the West Vancouver shore-line to Whytecliff was arranged for 90 nursing sisters. Following the drive the guests were received by Edna Rossiter, Unit president, at the beautiful Marine Drive home of Mrs. Ronald Graham, who had graciously extended an invitation to tea. The weather was perfect enabling the guests to enjoy the lovely gardens before partaking of tea on the terrace.

The fall meeting was held in October and the annual Armistice Dinner took place at Hotel Georgia in November. A wreath was placed on the Cenotaph at the Armistice Day service.

During 1949 a total of 197,096 persons in British Columbia were examined by the chest survey clinics, including 140,722 who attended the mobile clinics. The new cases of tuberculosis found by these clinics num-

bered 523, an increase of 22 per cent over the 1948 figure.

Among the white and Japanese populations the highest percentage of new cases occurred in the 30-39 age group. The greatest number of new cases among the Chinese population came in the 50-59 age group while among the Indians the largest concentration of new cases fell in the 10-14 age group.

—Tuberculosis Control Report, 1949

News Notes

BRITISH COLUMBIA

Kamloops-Okanagan District

Kamloops was the scene of the district annual meeting held in October when the guest speaker was Lorna Horwood, assistant professor in public health nursing, University of British Columbia. Her topic—"World Health Organization"—was enthusiastically received by the members. Mrs. R. Dalgleish was hostess at a tea in honor of Miss Horwood when M. H. MacKay, superintendent of nurses, Royal Inland Hospital, poured. A dinner meeting at the Plaza Hotel followed when Mrs. M. Rolph, district president, was in the chair. Sixty members were present, including a student delegate.

Reports were received from the chapters and M. Davies, district travelling delegate, told of the C.N.A. biennial convention which she attended in Vancouver. There was considerable discussion on the establishment of a rest home for aged and incapacitated nurses. This project was proposed by the district at the provincial annual meeting. The feasibility of such a scheme will be further studied by the chapters. It was unanimously decided that a resolution, requesting proportional representation and secret ballots on all matters pertaining to provincial policy, be presented at the next annual provincial meeting.

Mrs. M. Hopgood moved a vote of thanks to the retiring executive and Nan Stuart thanked the Kamloops Chapter for their hospitality. In future, there will be two meetings of the district association—one prior to the annual provincial meeting and the annual meeting in October.

The following officers will serve during the coming months: President and councillor, Mrs. E. Ransom, Tranquille; vice-presidents, M. Davies, Kelowna; B. Donaldson, Kamloops; secretary-treasurer, E. Stewart, Kamloops.

Vancouver Island District

The fall meeting of Vancouver Island District was held at Comox Hospital with Plateau Chapter as hostess. The district president, Sr. M. Claire, of Lourdes Hospital, Campbell River, was in the chair. Fifty-two nurses, representing five chapters, took part

in a lively discussion of current problems, led by Mrs. M. Botsford, assistant registrar, R.N.A.B.C. It was revealed that in some countries nurse registration is directed by the labor department, department of interior, etc., but in B.C. nurses themselves have set up their own councils and have gradually evolved standards, requirements, and qualifications which have been legally protected since 1918. In 1947 the constitution was changed and a testing program approved whereby nurses from other countries may be examined and qualify for B.C. registration. Mrs. Botsford explained how a nurse's professional status is thus legally recognized and safeguarded. Problems relating to the shortage of graduate nurses in the smaller hospitals were discussed and affiliation with the rural hospital may soon form part of the required curriculum in the school of nursing.

Ferne Trout, R.N.A.B.C. itinerant instructor, is giving refresher courses for nurses in outlying districts. Hospital boards have expressed appreciation of these courses and the nurses themselves are enthusiastic.

Chilliwack

Twenty-two members were present at the first fall meeting of Chilliwack Chapter with the vice-president, A. C. Cleland, in the chair. Three new members were welcomed. Mrs. F. Storey, as delegate to the Local Council of Women, gave a report on meetings attended and read part of a talk given to the Council by Alice Wright, registrar, R.N.A.B.C., on "Why the Entrance Standard for Student Nurses Must Remain High." Mrs. Storey reported that members were invited to the semi-annual convention of the Council. Mrs. F. Barwell, on behalf of the Red Cross, called for volunteers to conduct a series of classes on home nursing, emergencies, baby care, also for volunteers for emergency Red Cross work. Plans were also made for the rummage sale under the convenership of Mrs. Storey. Miss Cleland, as delegate to the C.N.A. biennial convention in Vancouver, gave an entertaining report.

Duncan

The Duncan section of the Cowichan-Newcastle Chapter were hosts at a dinner meeting of the chapter when 50 nurses attended from Ladysmith, Chemainus, and Duncan. Elizabeth Stewart, the president, was in the chair. The guests for the evening were Dr. and Mrs. W. E. Cowell-Taylor of Duncan. Dr. Cowell-Taylor, a neurosurgeon, spoke on "Traumatic Neurosurgery, including the Nursing Aspects."

Kelowna

Mrs. H. M. Trueman presided at a recent meeting of Kelowna Chapter when it was approved that the chapter take out a membership in the Citizenship Council. Through this membership it will be possible to assist those nurses and non-professional hospital em-

ployees who are from European countries. Several nurses volunteered to canvass for the Community Chest under the leadership of Sheila Blackie. It was agreed to bring used clothing to a later meeting to be given to the newly organized clothing depot, sponsored by the Local Council of Women. Mrs. M. Patrick replaces Mrs. J. Kinnear as Educational Committee convener. Mrs. Kinnear now resides in Seattle, Wash. Mrs. M. Urquhart represented the chapter at the Kamloops-Okanagan district meeting held in Kamloops in October. H. Empey and M. Davies gave their reports on the C.N.A. biennial convention held in Vancouver. H. Benson, M. Barstal, and N. Stewart were welcomed as new members.

Mrs. H. M. Trueman presided at a later meeting of the chapter when it was decided that the members sponsor a "Christmas Shopping Tea" during December. A sale of home-cooking will also be held at the same time. The feasibility of having a Valentine dance was discussed. Mmes M. Urquhart and L. Barre have been appointed as delegates to the Local Council of Women.

Mrs. M. Rolph, district councillor, was instructed to inform the council that the chapter is in favor of investigating the establishment of a home for aged nurses as suggested at the last district meeting. The chapter will also support the resolution requesting proportional voting and secret ballots which will be brought before the next provincial meeting from the district.

Brian and Gerry Mills entertained the members with piano accordian selections.

Port Alberni

Thirty members were present at a recent regular meeting of Alberni Valley Chapter when several new members were welcomed. Mrs. L. Rowan was in the chair in the absence of the president, Mrs. L. Caldwell. The guest speaker was Dr. Jean T. Hugill, of the West Coast Hospital staff, who spoke on "Anesthesia and Modern Methods of Surgery." An explanation of the different types of nerve blocks was a feature of her talk. Dr. Hugill plans to take a post-graduate course at Vancouver General Hospital.

Vancouver

The Vancouver Chapter joined with the Vancouver General Hospital Alumnae Association for their September meeting. The highlights of the C.N.A. biennial convention were presented by a panel discussion. Taking part in the program were: Alice Wright, registrar, R.N.A.B.C.; Trenna Hunter, second vice-president, C.N.A., and director of nursing service, Metropolitan Health Committee, Vancouver; Mrs. K. Johnson, director of practical nurse training, Vancouver Vocational Training School; Betty Jean Gunn, president, Student Nurses' Association of B.C., and intermediate student nurse at V.G.H.

St. Paul's Hospital

Bernadine Conroy of Kimberley has been awarded the alumnae bursary for this year. She is now taking public health nursing at the University of British Columbia. Hazel Hull has returned from Seattle where she received instruction in the operation of a new machine which administers peristaltic enemata. This treatment has been successful in restoring normal peristalsis of the bowel. Developed by a graduate of Providence Hospital, St. Paul's is the first hospital in Canada to acquire a machine of this type. Lyle Rolston and Pat Dumont are on the staff of Oliver Hospital. Aldine Zinck of Nanaimo was a visitor to Vancouver recently.

MANITOBA

BRANDON

Mrs. E. Griffin, the president, was in the chair at the first fall meeting of the Association of Graduate Nurses when reports from the various committees were received. The married nurses' group is making plans for a tea and sale of hand-made articles. Much appreciated donations for the Scholarship Fund were received and other means of increasing contributions were discussed.

NEW BRUNSWICK

NEWCASTLE

The formation of the Miramichi Chapter of the N.B.A.R.N. took place on October 19 at Miramichi Hospital when the following officers were elected:

President, Bertha Martin; vice-presidents, Mrs. L. Grady, H. Quann; secretary, Sr. MacKenzie; treasurer, J. Alexander. Committees: Entertainment, Mmes Vereker (chairman), B. I. Norriss, Sr. Skidd, J. R. Ross; publicity and *The Canadian Nurse*, Sr. Sanford (chairman), M. E. Wallace, A. S. Evans; constitution and by-laws, H. Lynds (chairman), Sr. Winslow, E. J. MacDonald.

ST. STEPHEN

The annual meeting of St. Stephen Chapter was held recently, preceded by a dinner attended by 42. The president, M. Dunbar, was in the chair. The annual reports revealed an active year on the part of the chapter. An interesting account of the N.B.A.R.N. annual meeting was given. Committees were appointed to arrange for the annual meeting of the provincial association, to be held in St. Stephen in 1951. Regret was expressed on the resignation of Mrs. R. Rogers, who left for Loon Lake, Sask., where her husband is in charge of a mission of the United Church. Chapter members, together with members of the Chipman Memorial Hospital, have pledged $1,617 toward the campaign of the Charlotte County Hospital Building Fund.

D. Parsons, formerly of Victoria Public Hospital, Fredericton, has joined the staff of Charlotte County Hospital as assistant superintendent. M. Malloy has resigned as instructor. K. Vaughn has returned from taking

a post-graduate course at Johns Hopkins Hospital and is operating room supervisor.

NOVA SCOTIA

DARTMOUTH

Helen Whitman has resigned her position as superintendent of nurses at the Nova Scotia Hospital. A number of special social functions in her honor were held. She was guest of honor at a tea, held at the nurses' residence, when Mrs. J. R. Smith, assistant superintendent of nurses, presided at the tea table. Miss Whitman, a graduate of the N.S. Hospital School of Nursing and the McGill School for Graduate Nurses, spent some time at her home in Annapolis County before leaving for Ontario.

ONTARIO

DISTRICTS 2 AND 3

OWEN SOUND

General & Marine Hospital

Mrs. D. McKerroll's home was the scene of a fall meeting of the alumnae association which took the form of a corn roast. It was decided to resume the bridge parties, the funds to go towards scholarships. Committees were elected to make arrangements for the 50th anniversary of the school of nursing to be celebrated in 1951.

The staff nurses are once again meeting bi-monthly. All officers were re-instated at the recent election, with the exception of the secretary and treasurer. Corrine Runnals and Jacqueline Thomson now fill these positions respectively.

Clara Metcalfe, a 1950 post-graduate student of the University of Toronto, has resumed the position of assistant director of nurses. J. Thomson, post-graduate student from the University of Western Ontario, is replacing Joan Sweatman as nursing arts instructor. Miss Sweatman is now instructor at Woodstock General Hospital. The following staff members are taking post-graduate courses at the University of Toronto: M. Cruickshank (public health); L. Metcalfe (teaching and supervision); and E. McDougal (surgical nursing).

DISTRICT 4

HAMILTON

General Hospital

The autumn meeting of the alumnae association took place recently when a brief business meeting was held, plans being discussed for the Mary Syme concert. Mrs. Fields, representing the class of 1938 B, was present with a display of their project—selling Christmas cards and story books to raise funds to purchase articles for the children's wing at the hospital. Miss Mayall, representative to the C.N.A. convention held in Vancouver, gave her report. She was assisted by B. Keayes, P. Dart, G. Blyth, and Miss Suckling, graduates, and Miss Hrynyshyn, a student. They gave an ex-

citing account of their trip out west, of the conferences, sight-seeing trips, banquets, etc.

M. Cameron and N. Querney of the O.R. staff have returned from Ann Arbor (Mich.) University where they attended the course given by Dr. Carl Walter on O.R. technique, followed by a week's observation in various O.R. rooms in Michigan.

Niagara Falls

The Greater Niagara General Hospital was the scene of a well-attended general meeting of Niagara Chapter when Misses Brown, O'Dell, and McKay gave interesting reports on the C.N.A. biennial convention held in Vancouver. Dorothy Sharpe showed excellent films of the convention and of the city of Vancouver. A social hour followed when refreshments were served by the hospital staff.

Port Colborne

Reta M. Brown has been appointed director of nursing at the new Memorial Hospital. Miss Brown, a native of Clarksburg, a Georgian Bay community, is a graduate of St. Michael's Hospital, Toronto. Following a year as operating room assistant at St. Michael's, she served for five years as assistant superintendent of nurses at Owen Sound General and Marine Hospital and then eight years as superintendent. For the past three years, Miss Brown has been assistant director of nursing at Victoria Hospital, London.

District 5

Toronto

The C.N.A. biennial convention in Vancouver was the topic of discussion at a district general meeting held in October. A large number of members were privileged to hear Helen G. McArthur, C.N.A. president, speak on the convention highlights. Other speakers who participated were: Marion Tresidder, district chairman; Edith Fenton, assistant secretary, R.N.A.O.; and Helen Carpenter, lecturer, University of Toronto School of Nursing. Following the discussion, Dorothy Sharpe, of District 4, showed colored slides of the convention and of Vancouver and other spots in British Columbia.

The district sponsored a play—"A New Addition of Spring Thaw" by the New Play Society—in the new Forest Hill Auditorium in November. The proceeds from the sale of tickets were used to reduce the C.N.A. token fee deficit and to replenish the savings account of the district.

QUEBEC

Montreal

Children's Memorial Hospital

A delightful social evening was held at Cottingham House when Madeleine Flander spoke on her trip to Vancouver to attend the C.N.A. biennial convention.

The following are recent staff changes: J. Thirlaway, to the teaching department; S. Wilson, to senior rotation; Misses Ellis, Tallon, and McGlynn as head nurses to Wards H, E, and K respectively. Recent appointments include: N. C. Stuppard, Winnipeg General Hospital; A. Cornelius, Miss Bankart, Montreal General Hospital; N. Pearson, Royal Victoria Hospital; M. Manning, T. Gribben, and J. O'Brien, St. Mary's Hospital; M. Woolley, A. Shearman, E. Braithwaite, Shriners' Hospital; B. McCaffrey, Jeffery Hale's Hospital, Quebec City. J. Anderson, M. Briggs, F. Burger, and D. Rourke have resigned from the C.M.H. staff —the latter two to be married.

Herbert Reddy Memorial Hospital

Mrs. Crewe, vice-president, was in the chair at the first meeting of the fall season held by the alumnae association, when new members were welcomed to the group. Following the business session, L. Hanson, recording secretary, gave an informal talk on her trip to Vancouver where she attended the C.N.A. biennial convention as hospital representative.

St. Mary's Hospital

The alumnae association hope that the coming months will prove both interesting and profitable. Last season the chief events were the annual communion breakfast, card party, and the dinner dance in honor of the graduation class. Guest speakers and films were features of the monthly meetings. A donation of $1,000 towards the furnishings of the new nurses' residence was made by the members as well as a contribution towards the V.O.N. affiliation and the annual hospital campaign plus gift parcels to overseas nurses and alumnae members who were ill.

SASKATCHEWAN

Fort Qu'Appelle

B. Johnstone has left the Sanatorium staff to take a position with the Department of Public Health in Regina. The following have joined the staff: H. Hoffman, H. Moffitt, and H. Wilson—all 1950 graduates of Regina Grey Nuns' Hospital; D. Gorr, J. Lightbody, and C. Rude—all 1950 graduates of Moose Jaw General Hospital.

Saskatoon

City Hospital

Twenty-one graduates of the hospital gathered in Toronto in October for a weekend of reunion activities. On Saturday afternoon an "after five" party was held, followed by a dinner at the King Edward Hotel. Margaret Neilson, supervisor of the convalescent department of the Hospital for Sick Children at Thistletown, gave an interesting address on the hospital in general as well as a description of her own department. On Sunday afternoon Ruth (Marland) Welsh and Jean (McKay) Robinson were joint

hostesses at a buffet supper. Marjorie (Halliday) Horner convened the arrangements for the reunion.

Following a two-day session of the Saskatchewan Hospital Association, the Women's Provincial Hospital Aids' Association announced they will offer an annual scholarship of $100 to the Grade XII student in the province with the highest academic standing who wishes to enter the nursing profession.

A fashion show and tea, under the auspices of the hospital auxiliary and nurses' alumnae, was held recently. For the finale of the show a group of nurses in uniform depicted the various years of their training.

Lucy Willis, educational and social director, is taking a course in personnel counselling and guidance at Teachers College, New York. A Toronto Western Hospital graduate, Miss Willis was chosen for a W. K. Kellogg Foundation Fellowship. Recent staff appointments include: M. (Mitchell) Burnett, B. (Andrews) Dunfield, T. (Bell) Dutton, I. Flanagan, J. McLaren, and P. Swenson.

St. Paul's Hospital

In October a tea was given at the School of Nursing to enable the graduate staff to meet Hazel Keeler who has been appointed director of the University of Saskatchewan School of Nursing. Rev. John Flanagan, S.J., executive director, Catholic Hospital Association for the U.S. and Canada, gave a talk to the students on "Present Day Trends of Nursing in the U.S." during the Catholic Hospital Convention held at the School of Nursing. An address was also given by Rev. H. L. Bertrand, S.J., president, Catholic Hospital Council of Canada.

A welcome was extended to R. Tinkiss who came to St. Paul's through the courtesy of the Division of Child and Maternal Hygiene, Ottawa. She is an authority on premature nursing care. Father Daniel Lord, S.J., also addressed the nurses on a recent visit.

Sr. B. Bezaire, superior, and Sr. Sauve attended the institute on hospital administration held in Winnipeg.

Saskatoon Sanatorium

Recent additions to the staff include the following graduates of schools of nursing from Vancouver to Moncton: L. Berglund, C. Felix, H. Lang, L. Barclay, V. Doskosh, C. (Bishop) Humbert, J. Erickson, V. Gillespie, F. McNutt, L. Fisher, V. Buchanan, Juan Johnson, M. (Findlay) Coward, M. Mathieson, M. Larsen, E. Schroeder, and C. (Steeve) Bruce.

The following resignations have been accepted: L. Johnson and V. Thorson to go to Swift Current; D. Hegre and A. Woolf to go to Lucky Lake. L. (Fast) Schmidt left with her husband for Montreal.

YORKTON

Chapter 4 held their annual bazaar-tea and sale of home-cooking in October. There was a good attendance.

Positions Vacant

Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.

Supt. of Nurses for Victoria Hospital, Winnipeg, Man. Apply, stating qualifications & salary expected, to Dr. J. R. Thomson at hospital.

Instructor (qualified) for Training School for Nurses, **General Duty Graduate Nurses & Dietitian** for modern 100-bed hospital in Central Manitoba town of 6,000 pop. 8-hr. duty. 1 mo. vacation after 1 yr. employment. Blue Cross Plan available. Good salary with full maintenance. Apply, stating qualifications, experience & salary expected, Supt., General Hospital, Dauphin, Man.

Instructor of Nurses for small hospital School of Nursing. Must be Registered Nurse. Complete maintenance provided. Apply, stating salary expected & giving qualifications, Supt., Plummer Memorial Public Hospital, Sault Ste. Marie, Ont.

Public Health Nurses immediately for Peel County Health Unit, Ont. Salary range: $1,900-2,500 depending on qualifications & experience. Car allowance. Generalized program in rural & semi-urban area. Write Medical Officer of Health, Court House, Brampton, Ont.

Public Health Nurse desiring experience in generalized health program in Southern Michigan, between Chicago & Detroit. Salary range depending on qualifications & experience: $3,000-3,300. Depreciation & mileage allowance on own car. 4 wks. vacation yearly; liberal sick leave. Field training area for public health nurses. Write Medical Director, District Health Dept., Hillsdale, Michigan.

General Staff Nurses for 500-bed hospital. 44-hr. wk. Rotating hrs. of duty. Must be registered in B.C. Apply Supt. of Nurses, St. Joseph's Hospital, Victoria, B.C.

Graduate General Duty Nurses for 50-bed General Hospital two blocks from sea & situated in delightful, renowned playground on Island Highway. Easy access to Vancouver & Victoria. Comfortable residence. References imperative. Basic salaries: $175 & $185 if one or more years' experience. Apply, stating age & experience, Lourdes Hospital, Campbell River, B.C.

General Duty Nurses for 35-bed General Hospital. Initial salary: $120 per mo. plus full maintenance. 48-hr. wk. 3 wks. vacation. Apply Supt., Stevenson Memorial Hospital, Alliston, Ont.

Graduate Nurses (2) for 20-bed hospital situated 200 miles southeast of Edmonton. Salary: $150 per mo. plus maintenance & uniform laundry. $1.00 per day bonus for night duty. Duties to commence Jan. 1. Apply V. Hanson, Matron, Municipal Hospital, Provost, Alta.

Clinical Supervisor. Apply Supt. of Nurses, Victoria Public Hospital, Fredericton, N.B.

Registered Nurses for General Duty. 8-hr. day, 48-hr. wk. Total 6 mos. day duty—6 mos. evening & night duty in yr. Gross salary: $145 per mo. days; $150 evenings & nights. Residence accommodation available. Apply Director of Nursing, General Hospital, Belleville, Ont.

Night Supervisor & General Duty Nurses. Apply, stating experience & qualifications, Supt., Queens General Hospital, Liverpool, N.S.

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Qualified ***Public Health Nurses*** for a generalized public health nursing service. Salary $2,087 with yearly increases to $2,504 per annum, plus $4.00 weekly Cost of Living Bonus. Five-day week. Sick leave and pension plan benefits.

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• DIETITIAN •

for 50-bed hospital. Full charge of department. Gross salary: $225-275 per month.

• **Supervisors (2)** also required. Must be *Registered Nurses*. 4:00-12:00 and 12:00-8:00 shifts. Gross salary: $200-210 per month. Extra money for 4:00-12:00 shift.

Apply, stating experience and qualifications, to **Supt., General Hospital, Cobourg, Ontario.**

• X-RAY AND LABORATORY TECHNICIAN •

for 50-bed hospital. Gross salary: $200-225 per month.

Registered and *Graduate Nurses* for **General Duty** also required. 8-hour day. 44-hour week. Statutory holidays. One month vacation and sick leave with pay.

Apply, giving experience and qualifications, to **Supt., General Hospital, Cobourg, Ontario.**

Asst. Supt. for 60-bed General Hospital. Salary commensurate with experience & training. Apply Supt., Public Hospital, Smiths Falls, Ont.

Registered Nurses for following positions with full maintenance in addition to salary: **General Duty Operating Room Nurse**—$130; **Head Nurse for Women's Floor** (34 beds)—$155; **General Duty Nurses**—$130 who alternate during day, afternoon & night shift; **Clinical Supervisor**—$160 per mo. Apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

British Columbia Civil Service requires: ***Registered Nurses for General Staff Duty for the Division of Tuberculosis Control***—*Vancouver Unit:* 225-bed T.B. Hospital, located at 2647 Willow St., Vancouver. All major services & student affiliation course. Registration in B.C. required. Gross salary: $182 per mo. Annual increments of $60 (over 5-yr. period). No residence accommodation. *Tranquille Unit:* 350-bed T.B. hospital, located 12 miles from Kamloops in southern interior. All major services except student affiliation. Gross salary: $188.50 per mo. Annual increments of $60 (over 5-yr. period). New modern residence; attractive bed-sitting rooms. Recreational facilities. Maintenance deduction: Room $5.00; laundry $2.50. Excellent food at 20 cts. per meal. ***Conditions—Both Units:*** 8-hr. day, 5½-day wk. rotating shifts. 4 wks. annual vacation with pay plus 11 statutory holidays. Sick leave, 20 days per yr. (14 cumulative). Promotional opportunities. Superannuation. Write for information & applications to Supt. of Nurses in respective Units or to Director of Nursing, Division of T.B. Control, 2647 Willow St., Vancouver, B.C.

Dietitian for 100-bed hospital. Salary depends on experience & qualifications. For particulars apply Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

WANTED

GENERAL DUTY NURSES

For Provincial Institutions in Province of New Brunswick

Salary: Minimum $1,620; maximum $1,740. Annual increase of $120 plus Monthly Bonus of 16%.

Comfortable living quarters and full maintenance supplied for $30 per month. Nurses' quarters open for inspection at any time.

Applications should be made to **Chairman, New Brunswick Civil Service Commission, P.O. Box 906, Fredericton, N.B.**

• DIRECTOR OF NURSING •

Applications will be received by the undersigned for the position of Director of Nursing at the **City Hospital, Saskatoon, Saskatchewan**—a 350-bed General Hospital. Duties will include those of the Principal of the School of Nursing. Position open ***January 1.*** *L. T. Muirhead, General Superintendent.*

Graduate Nurses for completely modern West Coast hospital. Commencing salary: $185 per mo. less $40 for board, residence, laundry. Special bonus of $10 per mo. for night duty. $10 annual increment. 44-hr. wk. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. accumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Graduates with Operating-Room experience for duty in modern, well-equipped Operating-Room Dept. Gross salary: $38-44 per wk. Opportunities for advancement to Staff positions for qualified graduates. Apply C. E. Brewster, Supt. of Nurses, General Hospital, Hamilton, Ont.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross salary: $38-44 per wk. 88-hr. fortnight. Hospitalization & medical benefits if ill. Apply C. E. Brewster, Supt. of Nurses.

Registered Nurses for General Duty at Grand Forks (B.C.) Community Hospital—30 beds. 44-hr. wk. Cumulative sick leave, statutory holidays & 2 wks. after 6 mos. service & 1 mo. after 1 yr. service. Gross salary: $175, less $30 which includes meals, laundry, living accommodation in hospital residence. Railway fare up to $50 with 1 yr. service. Splendid climate. Good shopping facilities locally with easy access to Nelson & Penticton, B.C., & Spokane, U.S.A. Apply John A. Hutton, Sec., Grand Forks, B.C.

General Duty Nurses. Gross salary: $163.40 per mo. 8-hr. broken day, 48-hr. wk. All salaries have scheduled rate of increase. Cumulative sick leave. Pension Plan in force. Blue Cross Plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

General Staff Nurses for Operating Room work, preferably with Operating Room experience. 8-hr. day, 48-hr. wk. 1 day off. Beginning salary dependent upon experience & preparation. Vacation & sick time on salary granted. Large active Operating Rooms. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

Registered Nurses for General Staff in 21-bed hospital. Salary: $140 per mo. Room, board and uniform laundry provided. Rotating shifts, 48-hr. wk. Blue Cross plan. 3 wks. holiday after one year's service. Apply Superintendent of Nurses, General Hospital, Espanola, Ont.

EXPERIENCE IN PSYCHIATRIC NURSING

The University of Western Ontario School of Nursing, in co-operation with **Westminster Veterans' Hospital, London,** and other community agencies, will offer to Graduate Registered Nurses a programme of study and guided experience in **Psychiatric Nursing,** to commence ***January 15, 1951.***

For further particulars write to:

The Dean, University of Western Ontario School of Nursing
London, Ont.

Trained Social Service Worker or **Public Health Nurse** with experience, for Ontario Cancer Foundation, Thunder Bay Clinic, Port Arthur General Hospital in association with Fort William & Port Arthur Units of Canadian Cancer Society. Duties of successful applicant will be in the nature of investigation & follow-up of cancer patients associated with this Clinic & as an educational officer in carrying out program of Cancer Societies. Possession of car an advantage but not essential. Duties to commence Jan. 1. Apply, stating age, training, experience, etc., & salary required, Ontario Cancer Foundation, Thunder Bay Clinic, General Hospital, Port Arthur, Ont.

Matron for new 8-bed hospital. Apply, giving particulars & salary expected, Sec., Manitou Hospital, Manitou, Man.

Registered Nurses (2) for new 8-bed hospital. 8-hr. day, 6-day wk. Full maintenance. Apply, giving particulars & salary expected, Sec., Manitou Hospital, Manitou, Man.

General Duty Nurses (2) for 20-bed modern hospital. Separate nurses' residence. 8-hr. day, 6-day wk. 1 mo. holiday after 1 yr. service. Salary: $150 plus full maintenance. Apply Alice Bildfell, Matron, Union Hospital, Rose Valley, Sask.

Supt. of Nurses for 53-bed hospital—urgent. A most interesting set-up is offered with adequate living accommodation & fair salary. Selected applicant must be able to also act as Principal of School of Nursing which is planned for near future. General administration & business of hospital is carried on by administrator. Apply, stating salary expected, references, etc., Administrator, All Saints' Hospital, Springhill, N.S.

Registered Nurses for Staff Duty—full or part-time. New depts. are being equipped & will be ready for patient care in near future. Apply Director of Nursing Service, Mt. Carmel Mercy Hospital, 6131 W. Outer Drive, Detroit 35, Michigan.

Registered Nurses for General Duty in 25-bed General Hospital. Salary: $140 per mo. plus full maintenance. 44-hr. wk. Apply Supt., Louise Marshall Hospital, Mount Forest, Ont.

Registered Nurses (2) for 10-bed country hospital in Saskatchewan. Salary: $150 per mo. & full maintenance. Usual holidays. Apply Matron, Union Hospital, Spalding, Sask.

General Staff Nurses for medical, surgical, delivery room & nursery divisions. Permanent night or afternoon duty or rotating periods. 210-bed hospital in attractive residential suburb of Chicago. 6 holidays. 2 wks. vacation with pay. 44-hr. wk. Salary: Days, $210; evenings, $220; night, $225. Living accommodation available in nurses' home or modern apt. building. Salary increase $10 per mo. after 60 days' satisfactory service. Apply Director of Nursing, MacNeal Memorial Hospital, 3249 So. Oak Park Ave., Berwyn, Illinois.

Clinical Supervisor for immediate opening. Degree required. To conduct supervisory & educational program for graduate nursing staff & to act as assistant to Director of Nursing. Salary range: $250-275 plus full maintenance. 210-bed General Hospital in residential suburb of Chicago. Apply Director of Nursing, MacNeal Memorial Hospital, 3249 So. Oak Park Ave., Berwyn, Illinois.

Asst. Supt. for 125-bed hospital for the Chronically Ill. New wing being planned. Special consideration given to applicant who is accustomed to meeting public, preferably a nurse over 35 yrs. of age. Apply, stating qualifications, religion, salary expected, Supt., Perley Home, Ottawa, Ont.

Official Directory

Provincial Associations of Registered Nurses

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Alberta Association of Registered Nurses

Pres., Miss Jean Clark, c/o Dept. of Health, Edmonton; Vice-Pres., Misses F. J. Ferguson, H. Penhale; *Councillor*, Rev. Sr. Annunciata, Mineral Springs Hosp., Banff; *Committee Chairmen: Institutional Nursing*, Miss F. McQuarrie, School of Nursing, Univ. Hospital, Edmonton; *Private Duty*, Miss J. G. Brown, 202 Anderson Apts., Calgary; *Public Health*, Miss K. Deane-Freeman, 216-17th Ave. W., Calgary; **Registrar, Mrs. Clara Van Dusen, Reynolds Bldg., 10026-102nd St., Edmonton.**

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The Association of Nurses of Prince Edward Island

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QUEBEC

The Association of Nurses of the Province of Quebec

The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec, Incorporated February 14, 1920.

Pres., Mlle A. Martineau; Vice-Pres. (*Eng.*), Rev. Sister M. Felicitas, Miss C. V. Barrett; Vice-Pres. (*Fr.*), Mlles F. Verret, R. Aubin; Hon. Sec., Miss H. Lamont; Hon. Treas., Mlle B. Laliberté; *Councillors*, Mlle M. Lacombe, Rév. Sr. Flore-Agnès, Mlles M. A. Trudel, J. Gagnon, L. Couet. The above constitute the *Executive Council* & are *Members of the Committee of Management*, together with: Mme M. A. Flynn, Mlles C. Demers, M. Bissonnet, G. Beauregard, Rév. Sr. St. Ferdinand, Rév. Mère Marie-Paule, Rév. Sr. Valérie de la Sagesse, Mlle G. Charbonneau, Miss M. Flander, Rév. Sr. Paul du Sacré-Coeur, Misses D. Goodill, I. Black. *Advisory Board*, Miss G. Hall, Rév. Sr. Valérie de la Sagesse, Misses M. S. Mathewson, M. E. Lunam, V. Graham, Mlle G. Lamarre, Miss E. C. Flanagan, Mme Boisvert. *Committee Chairmen: Institutional Nursing* (*Eng.*), Miss N. Mackenzie, Gen. Hosp., Montreal 18; (*Fr.*), Rév. Sr. D. Lefebvre, Institut Marguerite d'Youville, Montréal 25; *Public Health* (*Eng.*), Miss C. MacIntosh, 4275 Western Ave., Montreal 6; (*Fr.*), Mlle E. Merleau, 5302 ave Victoria, app. 2, Montréal 26; *Private Duty* (*Eng.*), Miss Wood, 212 Brock Ave., Montreal West 28; (*Fr.*), Mlle B. Labelle, 3622 rue St. Denis, Montréal 18. *Chairmen, Board of Examiners:* (*Eng.*), Miss A. Haggart, Royal Victoria Hosp., Montreal 2; (*Fr.*), Mlle Trudel, Hôp. Ste. Justine, Montréal 10. **Sec.-Registrar, Miss Margaret M. Street. Visitor to Fr. Schools of Nursing, Mlle S. Giroux. Association Headquarters, 504-6 Medical Arts Bldg., Montreal 25.**

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SASKATCHEWAN

Saskatchewan Registered Nurses' Association (Incorporated 1917)

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A.A., St. Joseph's Hospital, Victoria

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A.A., Children's Hospital, Winnipeg

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A.A., Brockville General Hospital

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A.A., Ontario Hospital, Brockville

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A.A., Public General Hospital, Chatham

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A.A., St. Joseph's Hospital, London

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A.A., Victoria Hospital, London

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A.A., Ottawa Civic Hospital

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